

12598

CERTIFICATE OF DEATH

Reg. Dist. No.

173

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Ranier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Christina</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 1898</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Henry Knott</u>				14. MOTHER'S MAIDEN NAME <u>Georgianus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatitis</u> (c) <u>Pyelonephritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 months</u> <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 6, 1956</u> to <u>Dec. 21, 1956</u> , that I last saw the deceased alive on <u>Dec. 21, 1956</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eino Magi</u>				ADDRESS (Street, city or town, state) <u>8401 University Lane, Silver Spring, Md.</u>			
DATE SIGNED <u>12/21/56</u>							
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee's Sons & NE DC</u>				ADDRESS <u>3004 85</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 27 1956

RECEIVED

12633

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>26 E Montgomery ave.</u>	

3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Arnold</u>		4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 8, 1956</u>
9. AGE (In years last birthday) yrs. <u>5</u> Months <u>31</u> Days <u>31</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Walter T. Arnold</u>	
14. MOTHER'S MAIDEN NAME <u>Charlotte Clement</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother</u> Address <u>Same.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs 31 min.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Dec 8, 1956</u> to <u>Dec 9, 1956</u> that I last saw the deceased alive on <u>Dec 8, 1956</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u>	
ACTUAL SIGNATURE <u>W.G. Hall</u>		DATE SIGNED <u>12-10-56</u>	
PHYSICIAN'S NAME (Type) <u>W.G. Hall</u>		<u>615 W. Montg. Ave. Rockville, Md. 12-10-56</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-11-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md</u>	24a. REC'D BY REGISTRAR <u>Ben M. Thompson</u>
		DATE <u>12-11-56</u>	24b. REGISTRAR'S SIGNATURE

2074213XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

DEC 13 1956

RECEIVED

12634

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4513 Saul Rd.				d. STREET ADDRESS 4513 Saul Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Martha Last ASMAN				4. DATE OF DEATH Month Dec. Day 5, Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-56		9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months 62 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert J. Asman				14. MOTHER'S MAIDEN NAME Mary E. Kane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) --		16. SOCIAL SECURITY NO. None		17. INFORMANT Address 4513 Saul Rd. Kensington, Md Robt. J. Asman, Jr. Father			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUFFOCATION DUE TO ASPIRATED VOMITUS 470x DUE TO RHINOPHARYNGITIS & LARYNGITIS Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 14 Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-4-56 , 19 56 , to 12-5 , 19 56 , that I last saw the deceased alive on 12-4-56 , 19 , and that death occurred at 9:41 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William S. Anderson		M.D. 1901 Wyoming Ave. NW		ADDRESS (Street, city or town, state) Wash DC		DATE SIGNED 12/5/56	
PHYSICIAN'S NAME (Type) William S. Anderson		1901 Wyoming Ave. N.W., Washington, DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-56		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Montgomery Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md		24a. REC'D BY REGISTRAR DATE 12-6-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

9VVVVVVVVXVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
DEC 7 1956
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12635

CERTIFICATE OF DEATH

12583

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>9318 WORTH AVENUE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Phillip Johnston Austensen</u>				4. DATE OF DEATH <u>12-18-56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-02</u>	
9. AGE (In years lost birthday) <u>54</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LEVI AUSTENSEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>577-03-2978</u>		17. INFORMANT <u>Phillip (son)</u> Address <u>9318 WORTH AVE. SS, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary thrombosis & embolism</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Myocardial Infarction & CHD</u> DUE TO (c) <u>Coronary arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>3 yrs</u> <u>Indef.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1, 1953</u> to <u>12/18/56</u> , that I last saw the deceased alive on <u>12/18/56</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rothville Md.</u> DATE SIGNED <u>12/18/56</u>			
PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey Jr.</u> ADDRESS <u>Silver Spring Md.</u>				24a. REC'D BY REGISTRAR <u>12-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

RECEIVED
DEC 31 1956
BUREAU V. R.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12636

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westwood Hills</u>			c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5237 Mass Ave - (Wash 14)</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Freeland</u> Last <u>Bachman</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1956</u>		
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-'03</u>	9. AGE (In years last birthday) <u>53</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Theatre manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>motoring</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
13. FATHER'S NAME <u>Jacob Bachman</u>			14. MOTHER'S MAIDEN NAME <u>Mary Tangier</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-05-3030</u>		17. INFORMANT <u>Philonema Bachman (wife)</u> Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-8-56</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u> </u>	22b. DATE THEREOF <u>12/11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) <u>Pr. Geo. Co., Maryland</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>			24a. REC'D BY REGISTRAR <u>12-11-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12599

CERTIFICATE OF DEATH

12585

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>2 hrs</u>				d. STREET ADDRESS <u>610 Gist Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rhoda Elizabeth Baxter</u>				4. DATE OF DEATH <u>12 / 20</u> 19 <u>56</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSW</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Vanderbilt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hosp Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral emboli</u> DUE TO <u>X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>Dec 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>56</u> , and that death occurred at <u>12:50</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W B Wardrop ml</u>				ADDRESS (Street, city or town, state) <u>837 Bonifant St. Beltsville</u>			
PHYSICIAN'S NAME (Type) <u>W. B. WARDROP</u>				DATE SIGNED <u>12/20/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm E. Humphrey</u>				ADDRESS <u>8434 1/2 Ave. S.S.M.D.</u>		24a. REC'D BY REGISTRAR <u>12/24/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 26 1956

RECEIVED

CERTIFICATE OF DEATH

12586

Reg. Dist. No. 216

12637

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4605 W. Virginia Ave.		e. STREET ADDRESS 4605 W. Virginia Ave	
3. NAME OF DECEASED (Type or print) First Middle Last OPAL DALEY BECK		4. DATE OF DEATH Month Day Year December 14, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1900
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months 10 Days 23	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Hugh Daley		14. MOTHER'S MAIDEN NAME Anna Shields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John M. Beck-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Progressive Bulbar Palsy DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Daventon 19 49 , to Daventon 19 56 , that I last saw the deceased alive on December 10 19 56 , and that death occurred at 6:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Y. Jagers Jr. M.D.		ADDRESS (Street, city or town, state) 5707 Wisconsin Ave	
NAME (Type) Frank Y. Jagers, Jr.		DATE SIGNED 12/15/56 Cherry Chase M.D.	
22a. BURIAL, CREMATION, REQUIEM (Specify) Burial	22b. DATE THEREOF 12/17/56	22c. NAME OF CEMETERY OR CREMATORY Parklawn	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR 12-181 06	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12587

12625 CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY <u>Tyner</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>South River, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor</u>				d. STREET ADDRESS <u>12201 Rockville Pike</u>			
3. NAME OF DECEASED (Type or print) First <u>Martha L.</u> Middle <u>B.</u> Last <u>Beckwith</u>				4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 16, 1880</u> 76 yrs	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Leander H. Zook</u>			
14. MOTHER'S MAIDEN NAME <u>Alice M. Merick</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>1-10-100000</u>				17. INFORMANT <u>Samuel J. Wilson</u> Address <u>2605 Southern Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-15</u> , 19 <u>46</u> , to <u>12-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-28</u> , 19 <u>56</u> , and that death occurred at <u>3:05 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl W. Craft</u>				ADDRESS (Street, city or town, state) <u>M.D. 2716 Kirtland Place</u>			
PHYSICIAN'S NAME (Type) <u>EARL W. CRAFT, M.D.</u>				DATE SIGNED <u>11. H. Gattrell, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>Jan 2, 1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl</u>				22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lewis Sons Co.</u>				ADDRESS <u>308 4th St. N.W.</u>			
24a. REC'D BY REGISTRAR <u>3/3/56</u>				24b. REGISTRAR'S SIGNATURE <u>Samuel J. Wilson</u>			

RECEIVED
DEC 1 1956
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12588

Reg. Dist. No. 214

12638

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2209 Forest Glen Rd.</u>				d. STREET ADDRESS <u>3800 New Hampshire Ave N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Bessie Carlotta Behrens</u>				4. DATE OF DEATH <u>Dec 25 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Carl Schnebel</u>				14. MOTHER'S MAIDEN NAME <u>Emma Piepenbring</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. ADDRESS <u>Carlton R. Behrens, 2209 Forest Glen Road, SS</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Bronhart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Bronhart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THIS OF <u>Dec. 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>12/27/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
V. B.

DEC 31 1956

LIBRARY
CITY OF NEW YORK

12639

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 months			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				d. STREET ADDRESS 7731 Bradley Boulevard			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7731 Bradley Boulevard				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clara Moran Bernheimer				4. DATE OF DEATH Month Day Year Dec 25, 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1881	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months Days Hours Min. 6 29	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music teacher		10b. KIND OF BUSINESS OR INDUSTRY self-retired		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Edward Moran				14. MOTHER'S MAIDEN NAME SK Susanna Lovelace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. \$77-09-0416B		17. INFORMANT Address Mrs. Joseph Ehrman-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis, generalizied DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of bladder DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 mos. 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma pt. breast						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 , to Dec 25, 1956 , that I last saw the deceased alive on Dec 25, 1956 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2828 Conn. Ave. N.W., Wash. D.C. DATE SIGNED 12/25/56							
ACTUAL SIGNATURE Armand B. Gordon, M.D.				PHYSICIAN'S NAME (Type) Armand B. Gordon, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/1956		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				24a. REC'D BY REGISTRAR DATE 12-29-56		24b. REGISTRAR'S SIGNATURE Bea E. Harrison	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. 1

12640

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS 244 West Notley Road			
3. NAME OF DECEASED (Type or print) First Americus Middle Edgar Last Biggs		4. DATE OF DEATH Month December Day 24 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/79
9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Justice of Peace		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Americus Biggs		14. MOTHER'S MAIDEN NAME Mary Ellen Whalen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO none	
17. INFORMANT Hospital Record (Son)		Address Archie A. Biggs Same as No. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO (b) 9 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 9 months		INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 52 , to Dec , 19 56 , that I last saw the deceased alive on Dec 24 , 19 56 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. D. Bonifant		DATE SIGNED 12/24/56	
PHYSICIAN'S NAME (Type) A. D. Bonifant, M. D.		ADDRESS (Street, city or town, state) Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/27/56	
22c. NAME OF CEMETERY OR CREMATORY NEELSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) NEELSVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner To Humphrey		24a. REC'D BY REGISTRAR 12-26-56	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur B. Lawler	

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12641

CERTIFICATE OF DEATH

Reg. Dist. No.

12591

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lawrenceville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sylvia Middle Regina Last BLACKWELL		4. DATE OF DEATH Month December Day 18 Year 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1956
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles (n) Blackwell		14. MOTHER'S MAIDEN NAME Sarah W Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT (Mother) Mrs. Sarah E. Thompson (Same As #2)		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub Endocardial Fibrosis elastosis 154.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 4 mths			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 August , 19 56 , to 18 December , 19 56 , that I last saw the deceased alive on 18 Dec. , 19 56 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Henry B. Karpinski M.D. U.S. Naval Hospital, Bethesda, Md. 12-19-56 PHYSICIAN'S NAME (Type) Henry B. Karpinski, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-56	
22c. NAME OF CEMETERY OR CREMATORY Private Church Cemetery		22d. LOCATION (City, town, or county) (State) Lawrenceville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.H. Bacon Funeral Home, 1722 7th St. N.W.		24a. REC'D BY REGISTRAR DATE 12-19-56	
24b. REGISTRAR'S SIGNATURE May E. Smith			

BUREAU V. S.

DEC 1930

RECEIVED

12600

CERTIFICATE OF DEATH

12592

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Lanley Park, Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanley Park, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>1 hour - 10 min</u>				d. STREET ADDRESS <u>8317 14th Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Philip</u> First <u>N.M.N. Bluestein</u> Middle <u>Bluestein</u> Last			4. DATE OF DEATH <u>December 18</u> 195 <u>6</u> Month Day Year				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-92</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>merchant</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. a</u>	
13. FATHER'S NAME <u>George Bluestein</u> <u>Not Available</u>				14. MOTHER'S MAIDEN NAME <u>Not Available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>patient's Hospital chart.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO (b) <u>Art. Hypertensive Heart Dis.</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1955</u> to <u>Dec 17, 1956</u> , that I last saw the deceased alive on <u>Dec. 17, 1956</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>915 - 19th St. NW</u> DATE SIGNED <u>Wash. D.C.</u>							
ACTUAL SIGNATURE <u>Leone Shulman</u> M.D.				PHYSICIAN'S NAME (Type) <u>1510 19th St. N.W.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New York</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin Thompson</u> ADDRESS <u>3501 - 14th St</u>				24a. REC'D BY REGISTRAR <u>2-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Benjamin Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 11 1964
BUREAU V. S.

RECEIVED
DEC 11 1964
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12593

Reg. Dist. No. 217

12642

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 24 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood	
3. NAME OF DECEASED (Type or print) Donnie Lee Bowling		4. DATE OF DEATH Month Dec. Day 8 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/56
9. AGE (In years last birthday) 1 yrs. 7 Months 7 Days		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME T.J. Bowling		14. MOTHER'S MAIDEN NAME Irene Seal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Hosp. Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Fracture of Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 24 hrs			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Was passenger in auto on head on collision	
20c. TIME OF INJURY Month, Day, Year 11 Hour XX P. M. 12/7 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md R- 32		20f. (City or town) (County) (State) Nr W. Fredship Howard Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Brosnhart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Brosnhart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/9/56	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 11, 56	
22c. NAME OF CEMETERY OR CREMATORY Siobon		22d. LOCATION (City, town, or county) (State) Howard, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonville	
24a. REC'D BY REGISTRAR DATE 12-12-56		24b. REGISTRAR'S SIGNATURE Calvin B. Lawler	

2073294 XV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 19 1956

RECEIVED

12643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. STATE <u>Dist of Columbia</u> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>69 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		4'	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium & Hospital</u>				d. STREET ADDRESS <u>2821 Rittenhouse St. NW.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jeremiah Christopher Broderick</u>				4. DATE OF DEATH Month Day Year <u>December 28 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 8, 1880</u>	9. AGE (In years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Broderick</u>				14. MOTHER'S MAIDEN NAME <u>Catherine O'Connell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Francis M. McCormick 2821 Rittenhouse St. Wash.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>177X</u> DUE TO						<u>5 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <u>WIDESPREAD METASTASIS</u> <u>6 mos.</u>	
(c) <u>CARCINOMA OF PROSTATE</u> <u>2 YRS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>OCT 1956</u> to <u>28 DEC 1956</u> , that I last saw the deceased alive on <u>26 DEC 1956</u> , and that death occurred at <u>5:35 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Charles J. Savarese Jr.</u> M.D.				<u>4861 BATTERY LANE 12/28/56</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE JR.</u>				<u>BETHESDA, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-31-56</u>		<u>MT. OLIVET</u>		<u>WASH D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Timothy Hanlon - 3831-GA Ave N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>12/31/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 31 1956
U.S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12596
2/6

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Surburban Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. STREET ADDRESS 4025 Plyers Mill Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle H. Last Brown				4. DATE OF DEATH Month Dec. Day 30, Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.		IF UNDER 24 HRS. Months 61 Days 61 Hours 61 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caddy				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Brown, Sr.				14. MOTHER'S MAIDEN NAME Jennie Warren			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Ethel Bradley (Sister)				Address 920 Fla. Ave. N.W. D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY 1-3-57 Arlington NAT'L Arlington, Va.				22d. LOCATION (City, town, or county) (State) 12-30-56			
23. FUNERAL DIRECTOR'S SIGNATURE JOSEPH SYERS CORNISHING 58				24a. REC'D BY REGISTRAR 21-21-105 N.W.		24b. REGISTRAR'S SIGNATURE 1/4/57 Bessie Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 2

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12601

CERTIFICATE OF DEATH

12597

Reg. Dist. No. 223

1 PLACE OF DEATH a. COUNTY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 21 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Katherine Marie Brown				4. DATE OF DEATH Month December Day 20 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-06	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Missouri		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Hugh P. Hammer				14. MOTHER'S MAIDEN NAME Marie True			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Hospital Records			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Accidents DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 24 hours 6 mos -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 4 , 19 56 , to Dec 20 , 19 56 , that I last saw the deceased alive on Dec 19 , 19 56 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest H. Sarao M.D.				ADDRESS (Street, city or town, state) 7006 NEW HAMPSHIRE AVE			
PHYSICIAN'S NAME (Type) ERNEST A. SARAO M.D.				DATE SIGNED 12/20/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
				22d. LOCATION (City, town, or county) (State) Washington Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur M. [Signature]				ADDRESS 254 Carroll St. N.W. By Day Washington, D.C.		24a. REC'D BY REGISTRAR DATE 11/1/56	
				24b. REGISTRAR'S SIGNATURE J. Arthur M. [Signature]			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 23 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12602 CERTIFICATE OF DEATH

12598
214

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 8202 ROANOKE AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ALFRED Last BURNETT				4. DATE OF DEATH Month DECEMBER Day 13 Year 1956			
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 26, 1864		9. AGE (In years last birthday) 92 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER				10b. KIND OF BUSINESS OR INDUSTRY NAVY DEPT. RETIRED		11. BIRTHPLACE (State or foreign country) BALT. MD	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tax, no. or unknown) NO		(If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT OLIVE M BURNETT Address 8202 Roanoke Ave Takoma Park Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 24, 1953 to DECEMBER 12, 1956 , that I last saw the deceased alive on Dec. 12, 1956 , and that death occurred at 8:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Israel Kessler M.D. 5801-16 45th NW, WASH, DC				DATE SIGNED 12-13-56			
PHYSICIAN'S NAME (Type) ISRAEL KESSLER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-15-56		22c. NAME OF CEMETERY OR CREMATORY LOUPON PARK		22d. LOCATION (City, town, or county) (State) BALTIMORE Md	
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home ADDRESS 4812 14th Ave NW WASH DC				24a. REC'D BY REGISTRAR 12/17/56		24b. REGISTRAR'S SIGNATURE Frances (Petter)	

BUREAU V. S.

DEC 10 1966

RECEIVED
FBI

12645
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Leslie Byram</u>				4. DATE OF DEATH Month Day Year <u>December 30, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1886</u>	9. AGE (In years last birthday) <u>70</u> yns.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unascertainable</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James N. Byram</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-28-5757</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of coronary arteries</u> DUE TO <u>myocardial infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic myelogenous leukemia</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour - a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)	
21. I certify that I attended the deceased from <u>December 17, 1956</u> to <u>December 30, 1956</u> , that I last saw the deceased alive on <u>December 30, 1956</u> , and that death occurred at <u>4:20 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Weissman</u>			M.D. <u>The Clinical Center</u>		DATE SIGNED <u>12/30/56</u>		
PHYSICIAN'S NAME (Type) <u>Sherman M. Weissman, M. D.</u>			<u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
<u>Cremation</u>		<u>1/2/57</u>	<u>Cedar Hill Cemetery</u>		<u>Scottland Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u>			ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>12 13 1956</u>	24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12645

CERTIFICATE OF DEATH

12600

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 3 MO			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				e. STREET ADDRESS 1720 34th Street, N.W.			
3. NAME OF DECEASED (Type or print) JOHN T CAMPBELL				4. DATE OF DEATH DEC 24 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/4/1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interstate Commerce Commission				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME ARTHUR CAMPBELL				14. MOTHER'S MAIDEN NAME SARAH SCHWARTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Arthur J. Campbell				Address 5904 Cobalt Road, Washington 16, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 months 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Nov 27, 1956 to Dec 24, 1956 , that I last saw the deceased alive on Dec 27, 1956 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Stephen Hulburt				ADDRESS (Street, city or town, state) 3000 Dent Pl. N.W. Washington, D.C.			
PHYSICIAN'S NAME (Type) R. Stephen Hulburt, M.D.				DATE SIGNED Dec 24, 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR 12-27-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

NEW

1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12601

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN TOWN 3 MONTHS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2709 BLUE RIDGE AVENUE				e. STREET ADDRESS 2709 BLUE RIDGE AVENUE			
3. NAME OF DECEASED (Type or print) BRENDA JANE CARTER				4. DATE OF DEATH Month DEC. Day 17 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 15, 1956	
9. AGE (In years last birthday) yrs. 3 Months 2 Days 2 Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON, D.C.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ERNEST EUGENE CARTER			
14. MOTHER'S MAIDEN NAME MURIEL IMOGENE BOOTH				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT Address Mr. Ernest E. Carter, 2709 Blue Ridge Ave. Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to upper respiratory infection DUE TO (b) found dead Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) in bed DUE TO (c) 475X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERNAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22. ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Dec. 17, 1956			
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE THEREOF 12/19/56			
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY				22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR 12/20/56			
24b. REGISTRAR'S SIGNATURE Frances Potter				9VVVVVVVVXVV			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 20 1950

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12602

12603

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hyattsville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>3 hr - 10 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. H. H. Hospital</u>		e. STREET ADDRESS <u>7906 - 15th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>YOLANDA</u> Last <u>CHEN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Yellow</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-52</u>
9. AGE (In years last birthday) yrs <u>3</u> Min. <u>10</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Homer Hingjen Chen</u>		14. MOTHER'S MAIDEN NAME <u>America Sanchez</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal atelectasis</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Congenital abnormality; possible Mongolism</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 17</u> , 19 <u>56</u> , to <u>Dec 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 18</u> , 19 <u>56</u> , and that death occurred at <u>12:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert J. Friedel</u> M.D. <u>6826 Rapp Rd Hyattsville, Md</u>		DATE SIGNED <u>12/18/56</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT J. FRIEDEL</u>		ADDRESS <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 19, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walker</u> ADDRESS <u>254 Carroll St. N.W. Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>1/20/56</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 28 1956

BUREAU V. 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12648

CERTIFICATE OF DEATH

12603

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Virginia COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 57 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 514 Rosemary Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Douglas Middle Sigmund Last Chmura				4. DATE OF DEATH Month December Day 11th Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1948	
9. AGE (In years lost birthday) 8 yrs.		IF UNDER 1 YEAR Months 8 Days 11 Hours 19 Min 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Virginia	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sigmund Chmura				14. MOTHER'S MAIDEN NAME Nettie F. Guzik			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cerebral hemorrhage DUE TO 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Acute Lymphocytic leukemia							INTERVAL BETWEEN ONSET AND DEATH 2 mo 9 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from October 15, 1956 , to December 11, 1956 , that I last saw the deceased alive on December 11, 1956 , and that death occurred at 9:56 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12/11/56 DATE SIGNED							
ACTUAL SIGNATURE James R. Stabenau M.D.				The Clinical Center			
PHYSICIAN'S NAME (Type) James R. Stabenau, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-12-56		22c. NAME OF CEMETERY OR CREMATORY NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Murphy				ADDRESS 3327 Columbia Rd. Arlington, Va.		24. REC'D BY REGISTRAR 2-12-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Hornsman			

BUREAU A. S.

1916

RECEIVED

12649

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 Grafton Street		d. STREET ADDRESS 25 Grafton Street	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FREDRIC Last COLCLOUGH		4. DATE OF DEATH Month December Day 31 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1870
9. AGE (In years last birthday) 86 yrs		10. USUAL RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Protestant Episc.	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Colclough		14. MOTHER'S MAIDEN NAME Maria Ellen Mackney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 10	
17. INFORMANT Vice Adm. O.S. Colclough,		Address 25 Grafton Street, Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema acute 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basal Gaster intestinal malignancy.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 7 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/1/54 to 12/31/56 that I last saw the deceased alive on 12/31/56 and that death occurred at 8:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Kleh		M.D. 915 19th St. NW, Washington, DC	
PHYSICIAN'S NAME (Type) JACK KLEH		DATE SIGNED 12/31/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/57	
22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sambo's Sons		ADDRESS 1736 Pennsylvania Ave. N.W., Washington, DC	
24a. REC'D BY REGISTRAR DATE 1-5-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 8 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12650

CERTIFICATE OF DEATH

12605

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. STATE West Virginia c. COUNTY Mercer			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 216 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center				d. STREET ADDRESS 1625 Augusta Street			
3. NAME OF DECEASED (Type or print) First Mary Middle Alice Last Collins				4. DATE OF DEATH Month December Day 27th , Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1944	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School girl		10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold E. Collins				14. MOTHER'S MAIDEN NAME Ruth Oliver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disto-intestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic leukemia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 25, 19 56 to Dec. 27, 19 56 , that I last saw the deceased alive on Dec. 27, 19 56 , and that death occurred at 10:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/28/56 ACTUAL SIGNATURE James R. Stabenau M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) James R. Stabenau, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - 11		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Monte Vista		22d. LOCATION (City, town, or county) (State) Mercer Co. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-29-56	
				24b. REGISTRAR'S SIGNATURE B. A. H. H. H. H. H.			

W. A. B. 10000

Received

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 213

12626

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>209 Adolares Rd.</u>				d. STREET ADDRESS <u>209 Adolares Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Laura Marie Cooperman</u>				4. DATE OF DEATH <u>Dec 31 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-56</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Richard M Cooperman</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father - Same as #2</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart failure</u> 704.4 DUE TO <u>Multiple Congenital Enormities of heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>of heart</u> DUE TO (c) <u>of heart</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>dead on birth</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brain lip and cleft palate</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey-Bethesda, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Laurel Kragtorp</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU A. 7

1957

DEAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12607

CERTIFICATE OF DEATH

Reg. Dist. No. 217

12651

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Roanoke	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roanoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hospital		d. STREET ADDRESS 1061 Hunt Ave. N.W.	
3. NAME OF DECEASED (Type or print) First Clara Middle B. Last Criner		4. DATE OF DEATH Month Dec. Day 31 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1894
9. AGE (in years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 6 Days 20 Hours 10 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Bluefield, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles B. Suter		14. MOTHER'S MAIDEN NAME Annie F. Akers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs L. E. Jones, Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer of Liver 1532 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Cancer of Rectum DUE TO (c) Polypsis of Rectum & Colon		INTERVAL BETWEEN ONSET AND DEATH 3 months 6-12 mos. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 10, 1956 to Dec 31, 1956 , that I last saw the deceased alive on Dec 31, 1956 , and that death occurred at 4:58 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gilcin F. Meadors, M.D.		ADDRESS (Street, city or town, state) Bover Clinic DATE SIGNED 1/1/57	
PHYSICIAN'S NAME (Type) Gilcin F. Meadors, M.D.		Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 3, 1957	22c. NAME OF CEMETERY OR CREMATORY Evergreen	22d. LOCATION (City, town, or county) (State) Roanoke, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Olun L. Mobaworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE 1-2-57		24b. REGISTRAR'S SIGNATURE Antwone B. Lowen	

STANTON V. S.

JAN 7 1907

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

12652

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u>1621 Newton St. N.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Jameson Deages</u>		4. DATE OF DEATH Month Day Year <u>12-21-1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1885</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Evans</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pumphrey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5423-5781</u>	
17. INFORMANT <u>Martina (daughter)</u>		Address <u>Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) <u>Generalized arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 15, 1956</u> , to <u>Dec. 21, 1956</u> , that I last saw the deceased alive on <u>Dec. 20, 1956</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter K. Angevine</u> M.D. <u>6300-13th St., N.W., Wash., D.C.</u>		DATE SIGNED <u>12-22-56</u>	
PHYSICIAN'S NAME (Type) <u>WALTER K. ANGEVINE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 11th St. N.W. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>Bea M. Thompson</u>	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUCKET V. 2
1952
1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12604

CERTIFICATE OF DEATH

12610

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington - Scitakium & Hospital</u>				d. STREET ADDRESS <u>7220 14th ST. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>INA DEE EDDINGFIELD</u>				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>cauc-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1880</u>		9. AGE (In years last birthday) <u>76 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social worker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Eddingfield</u>				14. MOTHER'S MAIDEN NAME <u>Bien Travers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>493</u> DUE TO (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>One week</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension and base, disease</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 20, 1956</u> to <u>Dec 26, 1956</u> that I last saw the deceased alive on <u>Dec 20, 1956</u> , and that death occurred at <u>9:55</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>		DATE SIGNED <u>12/27/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				ADDRESS <u>2801 14th St. N.W. Wash. D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>7/31</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. W. Van L...</u>			

TO HOSPITAL ATTEND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REC'D
DEC 31 1956
U.S. DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12611

Reg. Dist. No.

215

12653

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL) c. LENGTH OF STAY IN 1b 2 mos. 20 days d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. NAVAL HOSPITAL, BETHESDA, MD		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 631 N. Carolina Ave., S.E. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First HARRY Middle (mm) Last ESTEP		4. DATE OF DEATH Month DECEMBER Day 16 Year 1956	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Aug. 1882
9. AGE (In years birth day) 74 yrs.		IF UNDER 1 YEAR Months Days Hours M-in	IF UNDER 24 HRS Months Days Hours M-in
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Ret.)	
11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HARVEY NATHIEL ESTEP		14. MOTHER'S MAIDEN NAME DORA MORROW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I&II		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT HE, WASHINGTON, D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, Myocardium DUE TO (b) Atherosclerosis, Generalized DUE TO (c) Calcific Aortic Tenoses, Bronchopneumonia	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Approx. 2 1/2 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter Nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 5 p. m. 19 56		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 Sept. 1956 to 16 Dec. 1956 , that I last saw the deceased alive on 16 Dec. 1956 , and that death occurred at 11:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. G. Williams		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-18-56	
PHYSICIAN'S NAME (Type) R. G. WILLIAMS, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-21-56	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Chambers 517 11th St., S.E. Washington, D.C.		24a. REC'D BY REGISTRAR DATE 12-17-56 24b. REGISTRAR'S SIGNATURE Maya E. Parrelly	

RECEIVED

JAN 8 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12605

CERTIFICATE OF DEATH

12612

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>4 weeks</u>				d. STREET ADDRESS <u>302 K St N.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army - Hq.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGUERITE CECELIA FARRINGTON</u>				4. DATE OF DEATH <u>DEC 16 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1900</u>	
9. AGE (in years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Michael J. Farrington</u>				14. MOTHER'S MAIDEN NAME <u>Rennie Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>11</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>yes.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>11-19 1956</u> , to <u>Dec 16 1956</u> , that I last saw the deceased alive on <u>Dec 16 1956</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul V. Starr</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave</u> DATE SIGNED <u>12-15-56</u>			
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>				Takoma Park, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Collins</u> ADDRESS <u>3821-14th. NW. Wash D.C.</u>				24a. REC'D BY REGISTRAR <u>12/18/56</u>		24b. REGISTRAR'S SIGNATURE <u>John R. Bell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 may be retained by the hospital or attending physician. Page 2 of 3 may be retained by the funeral director. Page 3 of 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 26 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 218

12654

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gaithersburg				c. LENGTH OF STAY IN 1b I Year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg R.F.D. I			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) CECIL M FINNEYFROCK				4. DATE OF DEATH Month Dec , Year 18 Day 19 Hour 36			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept, 27 1920	
				9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Ora F. Finneyfrock				14. MOTHER'S MAIDEN NAME Cora V. Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Barron C. Finneyfrock Gaithersburg I			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia lobular				2 days			
DUE TO Multiple Sclerosis				6 years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan , 19 54 , to Dec. 18 , 19 56 , that I last saw the deceased alive on Dec 18 , 19 56 , and that death occurred at 9:00 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Vernon E. Martens M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Dec 19/56			
PHYSICIAN'S NAME (Type) Dr. Vernon E. Martens				Germantown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec. 22 56		Union		Rookville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. ...				24a. REC'D BY REGISTRAR DATE Dec 21-56		24b. REGISTRAR'S SIGNATURE Charles H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC

BUREAU W. C.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b SILVER SPRING d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4420 HEWITT ROAD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 4420 Hewitt Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SUSAN Middle M. Last FLEENOR		4. DATE OF DEATH Month DEC. Day 22 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/37
9. AGE (In years last birthday) 19 yrs.		10. UNDER 1 YEAR Months 19 Days 19	11. UNDER 24 HRS. Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILL CARROLL	
14. MOTHER'S MAIDEN NAME PEARL (unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. Elcaner Fleenor, Pennington Gap, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO BULLET WOUND 981X DUE TO IN SKULL Conditions, if any, which gave rise to immediate cause (b) IN SKULL (c), stating the underlying cause lost. IN SKULL DUE TO IN SKULL DUE TO IN SKULL			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year 9:00 Dec. 22, 56 Hour 9:00 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Silver Spring, Montgomery, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 12-22-56	
EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS.	22b. DATE THEREOF 12/24/56	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) PENNINGTON GAP, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 12/27/56	24b. REGISTRAR'S SIGNATURE Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

18 A M
Sent to SEC
JAN 11 1964

12656 CERTIFICATE OF DEATH

12615

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8909 Mohawk Lane</u>		d. STREET ADDRESS <u>8909 Mohawk Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIZZIE FLEMING</u>		4. DATE OF DEATH Month Day Year <u>Dec. 7 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse and Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Edith Fleming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Rebecca H. Spitzer, Bethesda, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>due to</u> Conditions, if any, which gave rise to immediate cause (b) <u>hypertensive heart disease</u> cause (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 7, 1956</u> to <u>Dec. 7, 1956</u> that I last saw the deceased alive on <u>Nov. 30, 1956</u> and that death occurred at <u>6:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. H. Mish</u>		DATE SIGNED <u>8519 Hazelwood Drive, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>K. H. Mish</u>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park,</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suorde</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 12-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bea M. H. in person</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO THE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1261's

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 mos. 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. STREET ADDRESS 5524 14th St., N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Felix Washington FOSTER				4. DATE OF DEATH Month Day Year December 26 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7 Oct. 1895		9. AGE (In years last birthday) yrs 61	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't (Retired)		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edmond Goster Foster				14. MOTHER'S MAIDEN NAME Melissa Newman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO Unknown		17. INFORMANT (Brother) George B. Foster, 502 S. Main St., Address Belmont, N.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 23 Oct. , 19 56 , to 26 Dec. , 19 56 , that I last saw the deceased alive on 26 Dec. , 19 56 , and that death occurred at 1:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-27-56							
ACTUAL SIGNATURE J.T. Horgan				M.D. U.S. Naval Hospital, Bethesda, Md. 12-27-56			
PHYSICIAN'S NAME (Type) J.T. Horgan, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Tryon Cemetery		22d. LOCATION (City, town, or county) (State) Tryon, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE W.D. Chambers ADDRESS Chambers, 3072 "M" St., N.W. Washington, D.C.				24a. REC'D BY REGISTRAR DATE 12-27-56		24b. REGISTRAR'S SIGNATURE May E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12617

Reg. Dist. No.

216

12655

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garret Park c. LENGTH OF STAY IN 1b Garret Park d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B & O R.R. Tracks near Garret Park			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garret Park d. STREET ADDRESS B & O R.R. Tracks near Garret Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last L. Melvin Frazier			4. DATE OF DEATH Month Day Year December 24, 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 72 ? yrs.	IF UNDER 1 YEAR Months Days Hours Min. 72 ? yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming-Self Emp.		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William Frazier			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT Address Wm. F. Frazier-Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries, Extreme DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Head fracturally depressed DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Struck by B & O. Passenger train					INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Struck by B & O. Passenger train			
20c. TIME OF INJURY Month, Day, Year 12-24-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B & O R.R.	
20f. (City or town) Garret Pk. Montg Md		20g. (State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-24-56	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/56		22c. NAME OF CEMETERY OR CREMATORY Oakland Church Cem.	
22d. LOCATION (City, town, or county) Oakland, Carrol Co., Md.		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DR-27-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Hampton					

U.S. AIR FORCE
9581 16 JBC
NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13111

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown RFD				c. LENGTH OF STAY IN life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Middlebrook)				d. STREET ADDRESS (Middlebrook)			
3. NAME OF DECEASED (Type or print) Samuel Arthur Bloyd				4. DATE OF DEATH Month Dec. Day 29 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/38	9. AGE (In years last birthday) 18 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Clements Gloyd				14. MOTHER'S MAIDEN NAME Nancy Cromwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT father - Same as # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 744.1 DUE TO Muscular Dystrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH Found dead in bed 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-31-56	22c. NAME OF CEMETERY OR CREMATORY St. Rose -		22d. LOCATION (City, town, or county) (State) Clopper - Md -		
23. FUNERAL DIRECTOR'S SIGNATURE Edmund B. Gartner				24a. REC'D BY REGISTRAR June 2-57		24b. REGISTRAR'S SIGNATURE Arden L. Conde	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12660

CERTIFICATE OF DEATH

12618

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 21 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS 409 Yorktown Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mark Middle David Last GRIFFITH				4. DATE OF DEATH Month December Day 26 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Dec. 1956		9. AGE (In years last birthday) yrs. 23	IF UNDER 1 YEAR Months 23 Days 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Thomas Roland GRIFFITH				14. MOTHER'S MAIDEN NAME Patricia ALDRED			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Thomas R. Griffith (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra ventricular hemorrhage 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) Prematurity. DUE TO c)							INTERVAL BETWEEN ONSET AND DEATH 23 1/2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital pulmonary atelectasis.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Dec. 1956 to 26 Dec. 1956 , that I last saw the deceased alive on 26 Dec. 1956 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Robert L. Baird		M.D. U.S. Naval Hospital, Bethesda, Md. 12-27-56					
PHYSICIAN'S NAME (Type) Robert L. Baird,		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 12-27-56	
				24b. REGISTRAR'S SIGNATURE Mary E. Passilly			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12619

12661

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Kenwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5822 Highland Drive			
3. NAME OF DECEASED (Type or print) First John Middle Henry Last GUNNELL				4. DATE OF DEATH Month December Day 30 Year 1956			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-79	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Henry GUNNELL				14. MOTHER'S MAIDEN NAME Caroline HOGENCAMP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Carolyn Y. HADLEY 5821 Goldsboro Road Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO (b) Over DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 years						INTERVAL BETWEEN ONSET AND DEATH Over 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 DEC , 19 56 , to 30 Dec , 19 56 , that I last saw the deceased alive on 30 Dec , 19 56 and that death occurred at 1032 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospit 1, Bethesda, Md. DATE SIGNED 12-30-56							
ACTUAL SIGNATURE T. S. DUNN, JR.		M.D. U.S. Naval Hospit 1, Bethesda, Md. 12-30-56					
PHYSICIAN'S NAME (Type) T. S. DUNN, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md. 12-30-56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES				ADDRESS Washington D. C. 2901 14th. Street N.W.		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE May E. Tassell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12662

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. STREET ADDRESS Rt. #3	
3. NAME OF DECEASED (Type or print) First Laura Middle Hamilton Last		4. DATE OF DEATH Month December Day 2 Year 19 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/03
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Johnson		14. MOTHER'S MAIDEN NAME Donnie Harmond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record (Husband)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis, Hypertension, Diabetes DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 10 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/21/56 to 12/21/56 , that I last saw the deceased alive on 12/21/56 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird, M. D.		DATE SIGNED 12/3/56	
PHYSICIAN'S NAME (Type)		ADDRESS Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/56	
22c. NAME OF CEMETERY OR CREMATORY Bells Chapel,		22d. LOCATION (City, town, or county) (State) Dickerson, Md.	
24a. REC'D BY REGISTRAR Robert L. Swindle		24b. REGISTRAR'S SIGNATURE Robert L. Swindle	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V 10 8

DEC 19 1956

RECEIVED

12663

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC. 7th, 1956, to DEC. 14, 1956, that I last saw the deceased alive on DEC. 14th, 1956, and that death occurred at 10:20 AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lawrence A. Rapee M.D. 1150 Conn. Ave. NW Wash. D.C. PHYSICIAN'S NAME (Type) LAWRENCE A. RAPEE DEC 14th 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 20 1950

BUREAU V. S.

12606 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>9 yrs.</u>				d. STREET ADDRESS <u>Georgia Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PALLS Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henrietta Maria Harding</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 24, 1867</u>	
9. AGE (In years last birthday) <u>89</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u> Hours <u>3</u> Min <u>30</u>		IF UNDER 24 HRS. Months <u>1</u> Days <u>21</u> Hours <u>3</u> Min <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Evening Star Newspaper</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Josiah Harding</u>				14. MOTHER'S MAIDEN NAME <u>MARY Virginia Valdena</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Mrs. Lillian I. PALLS</u>				Address <u>7420 Maple Ave. TAKOMA PARK, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 1, 1916</u> , to <u>Dec. 15, 1956</u> , that I last saw the deceased alive on <u>Dec. 16, 1956</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D. <u>7701 Canal Ave</u>							
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u> <u>Takoma Park, 12, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-18-56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Park Creek</u>		22d. LOCATION (City, town, or county) <u>Wash DC</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Amattangly</u> ADDRESS <u>131-11 St. Wash DC</u>				24a. REC'D BY REGISTRAR <u>DEC 18 1956</u>		24b. REGISTRAR'S SIGNATURE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1915-1916

12664

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Highland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Thomas</u> Last <u>Harding</u>		4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>19 576</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/75</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Noah Harding</u>		14. MOTHER'S MAIDEN NAME <u>Helen Augusta Tlehart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Hospital Record</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Urinary Retention</u> DUE TO (c) <u>Benign Prostatic Hypertrophy</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 month</u> <u>10 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>56</u> , to <u>12/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>56</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12/13/57</u>			
ACTUAL SIGNATURE <u>C. S. Whitaker</u> M.D. _____			
PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D.</u>		<u>Clarksville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-15-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>	22d. LOCATION (City, town, or county) <u>Highland, Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Nathan, Ellicott City, Md.</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>2-3-57</u> 24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Towler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

FEB 2 1957

RECEIVED
FEB 2 1957

12607

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lewisdale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hosp</i>		e. STREET ADDRESS <i>7505 23rd Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Zelma</i> Middle <i>(None)</i> Last <i>Harrison</i>		4. DATE OF DEATH Month <i>12</i> Day <i>24</i> Year <i>1956</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-10-1893</i>
9. AGE (In years last birthday) <i>63</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>NC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Pickney Reed</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>11082</i>	
17. INFORMANT <i>Hosp. Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary failure</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary artery disease</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 3</i> , 19 <i>56</i> , to <i>Dec 23</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Dec 23</i> , 19 <i>56</i> , and that death occurred at <i>8:12 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wayne Glick</i> M.D. <i>6826 Regg Rd, Hyattsville, Md</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>H. WAYNE Glick</i> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>12/26/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i> ADDRESS <i>2901 14th St. N.W. Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>J. Miller</i> DATE <i>12/27/56</i>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

EURAND V. S.

EC

1950-1951

INSTRUCTIONS

1 24 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the used copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12624

CERTIFICATE OF DEATH

12665

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING		LENGTH OF STAY (in this place) 20 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 607 MISSISSIPPI AVENUE				STREET ADDRESS (If rural give location) 607 MISSISSIPPI AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) FREDERIC (Middle) WILLIAM (Last) HECKMAN				(Month) DEC. (Day) 6 (Year) 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 24, 1888	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Loan Guarantee Agent, Veterans Adm.			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BRADFORD, MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB HECKMAN				14. MOTHER'S MAIDEN NAME ANNIE CONDON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES		16. SOCIAL SECURITY NO. 573-44-1669		17. INFORMANT & ADDRESS Mrs. Gladys G. Heckman 607 Mississippi Ave., Silver Spring, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				CARDIAC ARRHYTHMIA CORONARY THROMBOSIS CORONARY ATHEROSCLEROSIS			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. NONE				INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES 7 YEARS			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> al work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/22/1950 to 12/6/1956, that I last saw the deceased alive on 11/26/1956, and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
SIGNATURE Wayne B. Seewig				ADDRESS (Street, city, town, state) 915-19th Street, Washington, D.C.			
DATE 12/10/56				DATE SIGNED 12/7/56			
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF 12/10/56		NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE Francis J. Teller		25. FUNERAL DIRECTOR'S SIGNATURE Wayne B. Seewig		ADDRESS SILVER SPRING, MD.	

BRENNAN V. S.

DEC 10 1960

RECEIVED

12608

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>			d. STREET ADDRESS <u>11119 Midvale Road</u>		
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Frances</u> Last <u>Henderson</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14, 1886</u>		9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Sanford</u>			14. MOTHER'S MAIDEN NAME <u>Isabelle M^{re} Guire</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charts & Records - Washington San. & Hosp</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia bilateral</u> <u>151X</u> DUE TO (b) <u>toxemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <u>carcinoma of stomach</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 days</u> <u>6 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>heart - arteriosclerosis 10-19-56</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY: Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-18</u> , 19 <u>56</u> , to <u>12-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7930 George Ave</u> DATE SIGNED <u>12-21-56</u> ACTUAL SIGNATURE <u>John O. Robber MD</u> PHYSICIAN'S NAME (Type) <u>John O. Robber</u> <u>Silver Spring Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fletchers Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>King Geo. Co. Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert F. Humphrey</u>			24a. REC'D BY REGISTRAR <u>12/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>William Wood</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 23 1950

BUREAU V. S.

12666

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10006 ROGART ROAD.</u>				d. STREET ADDRESS <u>10006 ROGART ROAD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>BESS</u> Middle <u>AUSTIN</u> Last <u>HEYWARD</u>		4. DATE OF DEATH		Month <u>DEC.</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1881</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES B. AUSTIN</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN MANDEVILLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mr. Clarence Heyward, 10,006 Rogart Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>2 1/2 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, arterial</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November, 1955</u> , to <u>Dec. 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 4</u> , 19 <u>56</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James A. Roberts</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8907 Georgia Ave Silver Spring, Md 12/4/56</u>			
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>12/6/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clarence Heller</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BONNIE A.

DEC 19 1

1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 2 Fill in 1-1-56 et

12667

CERTIFICATE OF DEATH

12627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11013 Cone Lane Md</u>		d. STREET ADDRESS <u>11013 Cone Lane Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ben</u> Middle <u>Hinder</u> Last <u>Hinder</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1926</u> 70 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phila. Pa.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Benjamin E. Hinder</u>		Address <u>7809 Narverda Cir.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Gall Bladder</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 10</u> , 19 <u>56</u> , to <u>Dec 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>56</u> , and that death occurred at <u>11:15 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice A. Sislew</u>		ADDRESS (Street, city or town, state) <u>1801 Age St NW</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE A SISELW</u>		DATE SIGNED <u>Dec 7 '56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burned</u>	22b. DATE THEREOF <u>Dec. 9, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ches. Sholen</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Dugan</u>		ADDRESS <u>3501-1400W</u>	
24a. REC'D BY REGISTRAR <u>DEC 12 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. J. Hinder</u>	

BUREAU V. S.

DEC 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12668

CERTIFICATE OF DEATH

Reg. Dist. No.

1262814

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Dist. Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1625 Newton St. N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Lane Home 981 O Georgia Ave.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First CECIL Middle CALVERT Last HINES		4. DATE OF DEATH Month DECEMBER Day 28 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patent Attorney		11. BIRTHPLACE (State or foreign country) Balt. Maryland	
13. FATHER'S NAME Christian M. Hines		14. MOTHER'S MAIDEN NAME Dorah Calvert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 1-1-1-1-1-1-1-1-1-1	
17. INFORMANT C. Calvert Hines Jr.		Address Brinklow, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MARCH 3, 1956 to DEC 28, 1956 , that I last saw the deceased alive on DEC 28, 1956 , and that death occurred at 8:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Lowden		ADDRESS (Street, city or town, state) 5206 Norway Dr. Chevy Chase Md.	
PHYSICIAN'S NAME (Type) HENRY M. LOWDEN		DATE SIGNED 12/28/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 1 1957	22c. NAME OF CEMETERY OR CREMATORY Olney Cemt.	22d. LOCATION (City, town, or county) (State) Olney Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Francis W. Miller		24. REC'D BY REGISTRAR DATE 1/5/57	

BUREAU V. S.

JAN 8 1907

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12629

12627

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>13 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>305 Blaggett Drive</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Dauphin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> d. STREET ADDRESS <u>221 Hooper Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Hummel</u> Last <u>Houser</u> 4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>19 56</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/1/01</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marion Landis</u>				14. MOTHER'S MAIDEN NAME <u>Leah Hummel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. George Sargent - (Daughter)</u> Address <u>(1)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> 19 <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u> </u>				DATE SIGNED <u>12/1/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>12/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		22d. LOCATION (City, town, or county) <u>Middletown</u> (State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clyde D. Collier</u> ADDRESS <u>Middletown</u>				24b. REC'D BY REGISTRAR <u> </u> DATE <u> </u>		24c. REGISTRAR'S SIGNATURE <u>Laurel Hargrove</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

1956

RECEIVED

12630

CERTIFICATE OF DEATH

12669

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10105 Summit Avenue</u>		STREET ADDRESS <u>3334 Stuyvesant Place, N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>HENRIETTA DYER HOWARD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12-16-1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>3-6-85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>D.C.</u>
13. FATHER'S NAME <u>JOSEPH T. DYER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE HARVEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT & ADDRESS <u>H.P. HOWARD Son</u>		18. MEDICAL CERTIFICATION <u>Generalized carcinomatosis abdominal from carcinoma of sigmoid</u>	
19a. DATE OF OPERATION <u>Feb 3, Mar 8, Aug 27, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of sigmoid</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <input type="checkbox"/>	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21d. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>12-16-1956</u> to <u>present</u> , that I last saw the deceased alive on <u>12-16-1956</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>C. P. Ryland</u>		DATE SIGNED <u>4400-49 St NW Washington DC 12-16-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>12-18-56</u>	
DATE THEREOF <u>12-19, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>	
ADDRESS <u>Bethesda Md</u>		ADDRESS <u>D.C.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 11M

BUREAU V. S.

DEC 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12631

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10613 Eastwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel J</u> Middle <u>Hughes</u> Last <u>Hughes</u>				4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Heating & Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Clifton Forge, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>James B. Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Anne Marie Mathews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-44-2800</u>		17. INFORMANT <u>Hospital Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24. REC'D BY REGISTRAR <u>JAN 2 1957</u>	
						25. REGISTRAR'S SIGNATURE <u>J. E. H. DeWitt</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12670

CERTIFICATE OF DEATH

12632

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1200 Oronoco Street			
3. NAME OF DECEASED (Type or print) First Rebecca Middle (none) Last Jackson				4. DATE OF DEATH Month December Day 5 Year 1956			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1892	9. AGE (In years last birthday) 64 yrs	IF UNDER 1 YEAR Months 5 Days 19 Hours 56	IF UNDER 24 HRS. Months 5 Days 19 Hours 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Josh Pearson				14. MOTHER'S MAIDEN NAME Anna Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sanguinous pericardial effusion DUE TO (c) metastatic carcinoma of ovary						INTERVAL BETWEEN ONSET AND DEATH days months 19 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from October 31, 1956 to December 5, 1956 , that I last saw the deceased alive on December 5, 1956 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. W. Weiger, M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/5/56			
PHYSICIAN'S NAME (Type) Robert W. Weiger, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/6/56		22c. NAME OF CEMETERY OR CREMATORY Chuck Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria Va	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold J. W. Home				ADDRESS 311 N. Patrick St.		24. REC'D BY REGISTRAR DATE 11-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

BUREAU V. S.

DEC 14 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12633

12671

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY /			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 6 mos. 6 days.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 7715 Oxman Rd.			
3. NAME OF DECEASED (Type or print) First James Middle Bernard Last JARVIS				4. DATE OF DEATH Month December Day 14 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-29	9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Jarvis				14. MOTHER'S MAIDEN NAME Nellie Griswold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 1946 to 1951		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Wife) Shirley F. Jarvis (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Osteogenic Sarcoma (humerus pin) 196X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 June , 19 56 , to 14 Dec. , 19 56 , that I last saw the deceased alive on 14 Dec. , 19 56 , and that death occurred at 2:00 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W.H. Druckemiller				ADDRESS (Street, city or town, state) DATE SIGNED M.D. U.S. Naval Hospital, Bethesda, Md. 12-15-56			
PHYSICIAN'S NAME (Type) W.H. Druckemiller, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-15-56	
				24b. REGISTRAR'S SIGNATURE Dr. C. Cassilly			

BUREAU V. B.

DEC 19 1956

RECEIVED

12672 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sugarland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dawsonville, Md.				d. STREET ADDRESS Sugarland, Dawsonville			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last JOHNSON				4. DATE OF DEATH Month Dec. Day 13, Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1865	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel Johnson				14. MOTHER'S MAIDEN NAME Margaret Diggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT William Johnson Address Dawsonville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 8 days 10 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. hemiparalysis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6 December 1956 , to 13 Dec 1956 , that I last saw the deceased alive on 13 December 1956 , and that death occurred at 11 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith M.D.				ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 15 Dec 56			
PHYSICIAN'S NAME (Type) Gordon M. Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/16/56		22c. NAME OF CEMETERY OR CREMATORY St. Paul,		22d. LOCATION (City, town, or county) (State) Sugarland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Sander ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE 12 19 1956		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 3

BUREAU V. S.

12673 CERTIFICATE OF DEATH

Reg. Dist. No.

126354

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>602 DEERFIELD STREET</u>		d. STREET ADDRESS <u>602 DEERFIELD STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA</u> <u>AGNES</u> <u>JONES</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER</u> <u>9</u> <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 16, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HARRISON</u>		14. MOTHER'S MAIDEN NAME <u>LATCHFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Clarence Jones</u> Address <u>889 4th St. S.W.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 Days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 30</u> , 19 <u>56</u> , to <u>Dec 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 8</u> , 19 <u>56</u> , and that death occurred at <u>7:58 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 GEO. AVE. SILVER SPRING, MD</u>		DATE SIGNED <u>DEC. 9, 1956</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 11-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel Prince Georges - Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Howard</u> ADDRESS <u>Laurel, Md</u>		24a. REC'D BY REGISTRAR DATE <u>12/14/56</u>	24b. REGISTRAR'S SIGNATURE <u>Franklin C. Carter</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 1 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12636

12674

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9216 COLUMBIA BLVD.		d. STREET ADDRESS 9216 COLUMBIA BLVD.	
3. NAME OF DECEASED (Type or print) First LOTTIE Middle Gertrude Last JONES		4. DATE OF DEATH December 27, 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1865
9. AGE (In years last birthday) 91 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) ALEXANDRIA, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME IGNATIUS FORD	
14. MOTHER'S MAIDEN NAME CHARLOTTE G. Simpson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Fannie G. Kellum, 9216 Columbia Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Hypertension DUE TO Generalized arteriosclerosis DUE TO None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1948 to Dec. 26, 1956 , that I last saw the deceased alive on Dec 26, 1956 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John S. Rogers		M.D. 12/27/56	
PHYSICIAN'S NAME (Type) JOHN S. ROGERS		ADDRESS (Street, city or town, state) Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/31/56	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR 12/31/56		24b. REGISTRAR'S SIGNATURE Francis Potter	

BURTON V. S.

JAN 4 1971

RECEIVED

12675 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>139 Ritchie Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Sinton</u> Middle <u>Jordan</u> Last <u>Jordan</u>				4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-12</u>	9. AGE (In years lost birthday) <u>44</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>William Jordan</u>			
14. MOTHER'S MAIDEN NAME <u>Flay V. Williams</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>See A Jordan (brother)</u> Address <u>28 Ritchie Ave. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u>							<u>3 DAYS</u>
DUE TO (b) <u>CEREBRAL HEMORRHAGE, MASSIVE</u>							
DUE TO (c) <u>CEREBRAL ARTERIO-SCLEROSIS, HYPERTENSIVE HEART DISEASE, LAMINARIA</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Dec 26</u> , 1956, to <u>Dec 29</u> , 1956, that I last saw the deceased alive on <u>Dec 28</u> , 1956, and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arvin H. Tramm</u>				ADDRESS (Street, city or town, state) <u>237 Georgia Ave - Silver Spring, Md</u>			
PHYSICIAN'S NAME (Type) <u>Arvin H. Tramm</u>				DATE SIGNED <u>12-29-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arvin H. Tramm</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>Arvin H. Tramm</u>	
DATE				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 3 1957

BUREAU V. S.

12676

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <u>Montgomery</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. STREET ADDRESS <u>6100 Ridge Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Julia W. King</u>		4. DATE OF DEATH <u>12-26-1956</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-89</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Ticker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Wright</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Leslie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Thomas (son)</u>		Address <u>6100 Ridge Drive Bethesda</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension - Arteriosclerosis Heart Dis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> 19 <u>50</u> , to <u>December 26</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 26</u> 19 <u>56</u> , and that death occurred at <u>4:19</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5009 DelRay Ave, Bethesda Md</u> DATE SIGNED <u>12/26/56</u> ACTUAL SIGNATURE <u>Robert G. Angle M.D.</u> PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u> <u>5009 DelRay Ave. Bethesda, Md.</u> <u>12/26/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Walkers Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>12-29-56</u> 24b. REGISTRAR'S SIGNATURE <u>B. J. M. ...</u>	

2. 11.

1. 11. 1921

CERTIFICATE OF DEATH

Reg. Dist. No.

12639
223

12610

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Allie Middle Hunter Last Kirkman				4. DATE OF DEATH Month December Day 30 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-73		9. AGE (In years last birthday) 83 yrs	F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Clark Gwinn				14. MOTHER'S MAIDEN NAME Frances Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -----		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis + Gangrene (Toes) (c) -----							INTERVAL BETWEEN ONSET AND DEATH Estimated 1-day
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 12/7/1956 , to 12/30/1956 , that I last saw the deceased alive on 12/29/1956 , and that death occurred at 5:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Hare				ADDRESS (Street, city or town, state) Takoma Park, Md.			
PHYSICIAN'S NAME (Type) Robert A. Hare				DATE SIGNED 12/30/56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-1-57		22c. NAME OF CEMETERY OR CREMATORY Forest Hill		22d. LOCATION (City, town, or county) Gaithersburg (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Dutton				ADDRESS Gaithersburg, Md.		24. REG'D BY REGISTRAR JAN 2 1957	
				25. REGISTRAR'S SIGNATURE John Dodd			

BUREAU V. S.

1957

RECEIVED

12611

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. LENGTH OF STAY IN 1b <u>2 1/2 Mo</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>11700 Idlewood Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Alice Marie Kittredge</u>				4. DATE OF DEATH <u>Dec. 29 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-4-00</u>	
9. AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD., BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>J. R. Grossette</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>FRED G. KITTREDGE</u>		Address <u>SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>72.1 Abscess Sigmoid Area</u> DUE TO (b) <u>Ruptured Sigmoid Diverticulum</u> DUE TO (c) <u>Chr. Sigmoid Diverticulitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 16 1956</u> to <u>Dec. 29 1956</u> that I last saw the deceased alive on <u>Dec. 29 1956</u> and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul V. Starr</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.</u>			
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>				DATE SIGNED <u>12-29-56</u>			
22a. BURIAL, CREMATION, or other (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>12/31/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND R. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Chambers</u>				ADDRESS <u>5801 Cleveland Ave.</u>		24a. REC'D BY REGISTRAR <u>Paul V. Starr</u>	
				24b. REGISTRAR'S SIGNATURE		DATE <u>1 1957</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 3 1957

BUREAU OF

CERTIFICATE OF DEATH

Reg. Dist. No. 216

12677

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 4-22-56-12-8-56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurelton, Long Island			
d. STREET ADDRESS 146-22 - 230th Street				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) ANNA First Middle Last KRAMER				4. DATE OF DEATH Month 12 Day 8 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1890 3-15-1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 8 Days 23 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Jack Kramer - Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerosis heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Cerebral thrombosis				INTERVAL BETWEEN ONSET AND DEATH 10 minutes years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 1952 to 12/8/56 , 1956 that I last saw the deceased alive on 12/8/56 and that death occurred at 12 PM the causes and on the date stated above. ADDRESS (Street, city or town, state) 12600 Parkland Drive DATE SIGNED 12/8/56							
ACTUAL SIGNATURE Charles M. Weber M.D.							
PHYSICIAN'S NAME (Type) Charles M. Weber				Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-transit		12/8/1956		Montefiore		Queens Co. New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 2-11-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Hosen			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director or page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11 1951

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12678

CERTIFICATE OF DEATH

12642

Reg. Dist. No.

214

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Eva Middle V. Last Lancaster				4. DATE OF DEATH Month December Day 2 Year 1956			
5 SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1897		9 AGE (In years last birthday) 59 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY?
13 FATHER'S NAME Andrew Adams			14. MOTHER'S MAIDEN NAME Ella Jackson				
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT John Lancaster, Fairland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, intracerebral right 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain tumor? DUE TO (c) Undetermined							INTERVAL BETWEEN ONSET AND DEATH 48 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 30 , 19 56 , to Dec 2 , 19 56 , that I last saw the deceased alive on Dec 1 , 19 56 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arnon H. Traumm M.D.				ADDRESS (Street, city or town, state) 5237 Georgia Ave Silver Spring, Md			
DATE SIGNED 12-2-56							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/56		22c. NAME OF CEMETERY OR CREMATORY Good Hope		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE - 6-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

BUREAU V. T.

DEC 2 1954

RECEIVED

12679

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>6 yrs</u>				d. STREET ADDRESS <u>10105 McKenny Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10,105 McKENNY AVENUE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Beauford Langford</u>				4. DATE OF DEATH <u>December 17 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2, 1892</u>	
9. AGE (In years last birthday) <u>64 yrs</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done. If deceased was working life, even if retired) <u>Wholesale Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sylvester W. Langford</u>				14. MOTHER'S MAIDEN NAME <u>McLain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>253-03-4721</u>		17. INFORMANT <u>Gertrude Fune Langford</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>1956</u> that I last saw the deceased alive on <u>November 29, 1956</u> , and that death occurred at <u>2:18 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Richards</u> M.D.				ADDRESS (Street, city or town, state) <u>10110 Georgia Ave</u>			
DATE SIGNED <u>12-17-56</u>							
PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>				CITY <u>Silver Spring</u> MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Pumphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>12/20/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Potter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. C.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12680

CERTIFICATE OF DEATH

12644

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5 day</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haitian</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Surrounding</u>				d. STREET ADDRESS <u>3</u>			
3. NAME OF DECEASED (Type or print) First <u>Iden</u> Middle <u>Edmonia</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29 1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u>	IF UNDER 24 HRS Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hallman Swales</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Sarah L. Lee</u>		Address <u>32612th. Wash. D.C. N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive heart disease with</u> DUE TO (c) <u>cardiac enlargement</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks at least 2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 22</u> , 19 <u>56</u> to <u>Dec 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>56</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Caron H. Traum</u>				ADDRESS (Street, city or town, state) <u>837 Georgia Ave - Silver Spring, Md</u>			
PHYSICIAN'S NAME (Type) <u>Robert J. Shauden</u>				DATE SIGNED <u>12-6-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion,</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Zion, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Shauden</u>				ADDRESS <u>Rock Md</u>		24a. REC'D BY REGISTRAR <u>Bessie M. Thompson</u>	
				DATE <u>12-6-56</u>			

READ V. L.

DEC 7 1956

150150
DEC 7 1956

TO HOSPITAL or TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL or TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12681

CERTIFICATE OF DEATH

Reg. Dist. No.

12645

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 708 North Second Street	
3. NAME OF DECEASED (Type or print) First Alan Middle Dean Last Lesh		4. DATE OF DEATH Month December Day 7 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1950
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Phillip A. Lesh		14. MOTHER'S MAIDEN NAME Isabel Carmen Wiltrout	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral seizures DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 3, 1956 to December 7, 1956 , that I last saw the deceased alive on December 7, 1956 , and that death occurred at 9 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Gordon Long M.D.		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center Bethesda 14, Maryland 12-8-56	
PHYSICIAN'S NAME (Type) Robert Gordon Long, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12/9/56	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Norton, Kansas
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Harris Co. 2901-14th St NW WASH. D. C.		24a. REC'D BY REGISTRAR DATE 12-11-56	24b. REGISTRAR'S SIGNATURE 43 Cecil M. ...

BUREAU V. S.

REC. 10 1936

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

Item 11 Film 10 1 30-57 et

12682

CERTIFICATE OF DEATH

Reg. Dist. No.

12646

2/7

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville--Rural				c. LENGTH OF STAY IN 1b 2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Oscar Middle Ira Last Lessig				4. DATE OF DEATH Month Dec Day 16 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 6 1905	
9. AGE (In years and birthday) yrs 51		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer, U.S. Gov.				10b. KIND OF BUSINESS OR INDUSTRY Yvonne Indiana			
11. BIRTHPLACE (State or foreign country) U.S.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Oscar Lessig				14. MOTHER'S MAIDEN NAME Lena Von Zehrold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs Oscar Lessig, Poolesville, R. F. D. Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 105A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Colon (operated) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days + 1 1/2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9 Dec 1956 to 16 Dec 1956 , that I last saw the deceased alive on 15 Dec 1956 , and that death occurred at 2:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED 16 Dec 56 ACTUAL SIGNATURE Gordon M. Smith M.D. Gordon M. Smith, M.D. PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/56		22c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		22d. LOCATION (City, town, or county) (State) Danville, Va	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville, Md				24a. REC'D BY REGISTRAR DATE 12/17/56		24b. REGISTRAR'S SIGNATURE Charles W. Elgin <i>per 288</i>	

BUREAU V. S.

DEC 11

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12683

CERTIFICATE OF DEATH

12647

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSTINGTON		c. LENGTH OF STAY IN 1b 4 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSTINGTON GARDENS REST HOME		d. STREET ADDRESS 3308 HARPELL STREET	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle CATHERINE Last LINKINS		4. DATE OF DEATH Month DECEMBER Day 12 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 28, 1971
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMELANDER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALFRED LINKINS		14. MOTHER'S MAIDEN NAME LUCY DWYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Ada L. SINYARD, 11,501 Newport Mills, Wheaton, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 445 X IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH: 2 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 1951 , to December 12 1956 , that I last saw the deceased alive on December 6, 1956 , and that death occurred at 2:45 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. D. Bonifant		ADDRESS (Street, city or town, state) Sandy Spring, Maryland	
PHYSICIAN'S NAME (Type) A. D. Bonifant, M. D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/14/56	
22c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR 12/17/56		24b. REGISTRAR'S SIGNATURE Flanice Collier	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 22 1956

RECEIVED
FEB 22 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12684

CERTIFICATE OF DEATH

Reg. Dist. No.

12648
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1015 Busac Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Linda Middle Louise Last LLOYD		4. DATE OF DEATH Month Dec. Day 2 Year 19 56	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Oct. 1956
9. AGE (In years last birthday) yrs 1 Months 29 Days Hours Min. 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Theodore L. LLOYD, Jr.		14. MOTHER'S MAIDEN NAME Mary Louise MC MANUS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pachymeningitis, hemorrhagica, externa. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 340.5 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) internal hydrocephalus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Oct. , 19 56 , to 2 Dec. , 19 56 , that I last saw the deceased alive on 2 Dec. , 19 56 , and that death occurred at 12:40 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Howard A. Pearson M.D.		U.S. Naval Hospital, Bethesda, Md. 12-3-56	
PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-56	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Jacksonville, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. REC'D BY REGISTRAR DATE 12-3-56	
24b. REGISTRAR'S SIGNATURE R. A. Pumphrey			

RECEIVED

1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

12685

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9904 CAPITAL VIEW AVENUE				d. STREET ADDRESS 9904 CAPITAL VIEW AVENUE			
3. NAME OF DECEASED (Type or print) First MINNIE Middle ELIZABETH Last LOCKHART				4. DATE OF DEATH Month DEC. Day 5 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 27, 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHINEAS ORNDORFF				14. MOTHER'S MAIDEN NAME MARY ANN LINABERG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Charles R. Cleaves, 9904 Capital View Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420X DUE TO Conditions, if any, which gave rise to immediate cause (b) sudden (c) INTERVAL BETWEEN ONSET AND DEATH DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/8/56		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) MT. WILLIAMS, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MARYLAND				24a. REC'D BY REGISTRAR DATE 12/6/56		24b. REGISTRAR'S SIGNATURE Francis J. Miller	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MOREAU V. S.

NO. 100

100-100

12686

CERTIFICATE OF DEATH

12650

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3806 Baltimore Ave.		d. STREET ADDRESS 3806 Baltimore Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last ALBERT LAFAYETTE LOHM		4. DATE OF DEATH Month Day Year December 24, 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1884
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lawyer-Self Emp. W. Virginia	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George W. Lohm		14. MOTHER'S MAIDEN NAME Rose Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Genevieve H. Lohm-Item#2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, DUE TO hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential hypertension DUE TO Essential hypertension (c) Essential hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension			INTERVAL BETWEEN ONSET AND DEATH 4 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 24, 1956 , to Dec 24, 1956 , that I last saw the deceased alive on Dec 24, 1956 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/24/56			
ACTUAL SIGNATURE John J. Curry M.D.		PHYSICIAN'S NAME (Type) John J. Curry	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12/26/56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE - 27-56	24b. REGISTRAR'S SIGNATURE Bernice Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12612

CERTIFICATE OF DEATH

12651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>DC</u> b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>				d. STREET ADDRESS <u>4731 - 3rd St NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>FRANCIS</u> First <u>Sales</u> Middle <u>Macher</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1956</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-18-13</u>		
9. AGE (In years last birthday) <u>83</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor - Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Wm H Macher</u>				
14. MOTHER'S MAIDEN NAME <u>Mary ANN SHORT</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. _____				17. INFORMANT <u>Wash San + Hosp Records</u> Address _____				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>199.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Cardiac Failure</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u> <u>Terminal</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				
20f. (City or town) _____				20g. (County) _____				
20h. (State) _____				21. I certify that I attended the deceased from <u>6/3/56</u> , to <u>12/25/56</u> , that I last saw the deceased alive on <u>12/25/56</u> , and that death occurred at <u>12:50 PM</u> from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>				
DATE SIGNED <u>12/25/56</u>				PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u> <u>Takoma Park, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. - 2901 14th St. N.W.</u>				ADDRESS <u>Washington, D. C.</u>				
24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>				24b. REGISTRAR'S SIGNATURE _____				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 27 1956

RECEIVED
V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12613

CERTIFICATE OF DEATH

12652

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>11 mo.</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8500 Flower Avenue</u>			
e. STREET ADDRESS <u>8318 Haddon Drive</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MacHadden Mary MacKnight</u>				4. DATE OF DEATH <u>Dec 5 1956</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 26, 1870</u>	
9. AGE (in years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>London, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Harrison</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown to me</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Sanitarium Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> <u>400.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1956</u> , to <u>Dec 5, 1956</u> , that I last saw the deceased alive on <u>Dec 3, 1956</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2701 Carroll Ave</u> DATE SIGNED <u>12-5-56</u>							
ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D.				PHYSICIAN'S NAME (Type) <u>J. M. Whitlock, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>Aug. 6, 1956</u>		<u>Cedar Hill Crematory</u>		<u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll Ave</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>12/6/56</u>				<u>William A. Ed</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STAN V. S.

25.

1954-25

. 12687

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY						MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN 16 yrs.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Silver Spring, MD						3 yrs.						Silver Spring							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. STREET ADDRESS						f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
8820 Sundale Dr.						8820 Sundale Dr.													
3. NAME OF DECEASED (Type or print)						First Middle Last						4. DATE OF DEATH Month Day Year							
JAY						LAWIT						12/06/56 19							
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 22, 1928		68											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country)							
Retired						Grocery						Mesia							
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME						12. CITIZEN OF WHAT COUNTRY?							
Isaac Kalamut						Toba (Unknown)						Poland							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT							
no						150 22 3864						Silver Spring, Md. Address Paul Kalamut 8820 Sundale Dr.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MAIGNANCY OF LUNG (TYPE UNDETERMINED) 1 163X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH 3 mos					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
ARTERIO SCLEROTIC LARGE VASCULAR DISEASE																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour o. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)									
21. I certify that I attended the deceased from 10/31/56, to 12/30/56, that I last saw the deceased alive on 12/29/56, and that death occurred at 2:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) DATE SIGNED													
ACTUAL SIGNATURE George P. George M.D. 9404 Colville Rd Silver Spring Md 12/30/56																			
PHYSICIAN'S NAME (Type) George P. George																			
22a. BURIAL CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)									
burial				12/21/56		Rosenbaum Jewish				Rosenbaum, Ohio O.H.									
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE											
[Signature]						DATE 12/30/56													

LUCAS V. S.

AN 2

RECEIVED

12688 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY **Montgomery** MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **Silver Spring** LENGTH OF STAY (in this place) **4 1/2 yrs.**
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **Marilea Nursing Home 14511 Colesville Road**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Montgomery**
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Chevy Chase 15**
 STREET ADDRESS (If rural give location) **6124 Western Avenue**

3. NAME OF DECEASED:

(First) (Middle) (Last)
John C. F. McCLELLAN

4. DATE (Month) (Day) (Year)
 OF DEATH: **Dec. 25 19 56**

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widowed

8. DATE OF BIRTH:

Nov. 16, 1862

9. AGE last birthday **94** yrs.

IF UNDER 1 YEAR Months Days Hours Min.
1 9

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY:

Self-employed

11. BIRTHPLACE (State or foreign country):

Xenia, Ohio

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

David McClellan

14. MOTHER'S MAIDEN NAME:

Melvina Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS:

Mrs. Stanley E. Fisher-Same Item #2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

acute myocardial infarction

INTERVAL BETWEEN ONSET AND DEATH

5 min

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

chronic myocardial disease**years**

DUE TO

generalized arteriosclerosis**years**

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

None

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-20, 1955** to **12-25, 1956**, that I last saw the deceased

alive on **12-17, 1956**, and that death occurred at **7 P. M.** from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial-transit

DATE THEREOF

12/26/56

NAME OF CEMETERY OR CREMATORY

Woodland

LOCATION (City, town, or county)

Green Co.**Ohio**

DATE REC'D BY LOCAL REGISTRAR

12-27-56

REGISTRAR'S SIGNATURE

James P. [Signature]

24. FUNERAL DIRECTOR

Robert A. Pumphrey

ADDRESS

7557 Wisconsin Ave. Bethesda 14, Md.

MARGIN RESERVED FOR BINDING

7/16/2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12655

Reg. Dist. No.

12689

1-20-57

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville RFD #2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Bladensburg Rd. & Georgia Ave.				d. STREET ADDRESS Norbeck		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First August Middle McKelvin Last McKelvin				4. DATE OF DEATH Month 12 Day 10 Year 1956			
5. SEX male	6. COLOR OR RACE ool.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1888		9. AGE (An year (month) (day)) 68 yrs.	IF UNDER 1 YEAR Months 08 Days 08	IF UNDER 24 HRS. Hours 08 Min. 08
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Mc Kelvin				14. MOTHER'S MAIDEN NAME Frances Miles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. McKelvin Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Died while passenger on bus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		12/14/56		Mt. Pleasant,		Norbeck, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert K. Shorden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE 12/10/56	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUKLENO V. B.

EC 27 1956

12628
CERTIFICATE OF DEATH

Reg. Dist. No. ...

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		LENGTH OF STAY (in this place) <u>1 1/2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waverley</u>				STREET ADDRESS (If rural give location) <u>2002 - Osborne Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>Mcnehan</u> (Middle) <u></u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 19 1956</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 18, 1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. A. Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Alice Ruane - 4331 - Alhambra Wash. D.C.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>						<u>12 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Sclerosis - Hypertension</u>						<u>Unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>Dec. 19, 1956</u> to <u>Dec. 19, 1956</u> that I last saw the deceased alive on <u>Dec. 19, 1956</u> and that death occurred at <u>11:35 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>James M. Loftus</u> M.D.				ADDRESS (Street, city, town, state) <u>1673 - Park Road Wash D.C.</u>		DATE SIGNED <u>Dec 20 1956</u> (State)	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>12/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) <u>Suitland, Md.</u>	
24. REC'D BY REGISTRAR <u>James M. Loftus</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU

DEC 20 1950

RECEIVED
FBI
DEC 20 1950

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12658

Item 9, Film G208, 12/12/56 for CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 4000 Cathedral Ave., N.W.	
3. NAME OF DECEASED (Type or print) First Ellis Middle Bell Last MILLER		4. DATE OF DEATH Month December Day 8 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Dec. 1879
9. AGE (in years last birthday) 76 7/8		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY USMC (Retired)	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hiram C. Miller		14. MOTHER'S MAIDEN NAME Annie Downend	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1900 to 1936	
17. INFORMANT (Wife) Mrs. Wilhelmina Miller (Same As #2)		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease 440.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 months.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 Nov. 1956, to 8 Dec. 1956, that I last saw the deceased alive on 8 DEC. 1956, and that death occurred at 6:05 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE B. L. Canaga, Jr. M.D. U.S. Naval Hospital, Bethesda, Md., 12-8-56 PHYSICIAN'S NAME (Type) B. L. CANAGA, JR. CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons ADDRESS Wash. D.C. 1756 Penn Ave., N.W.		24a. REC'D BY REGISTRAR DATE 12-8-56	
24b. REGISTRAR'S SIGNATURE Joseph Gawler's & Sons			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1875

BRENNAN V. S.

DEC

1875

12691

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helan</u> Middle <u>Thomas</u> Last <u>Money</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/8/04</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Effie Bontz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of brain (infarction)</u> DUE TO <u>Thrombosis ant. cerebral artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 days</u> (c) <u>6 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>12</u> o. p. <u>2</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/2</u> , 19 <u>56</u> , to <u>12/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/29</u> 19 <u>56</u> , and that death occurred at <u>1:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>12/29/56</u>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Ligon, M. D.</u>		<u>Sandy Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Washington DC</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12692

CERTIFICATE OF DEATH

12660

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>24 hrs.</u>				d. STREET ADDRESS <u>7829 Old Chester Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Winiyred</u> Middle <u>MORAN</u> Last <u>MORAN</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-83</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Thomas MORAN</u>			
14. MOTHER'S MAIDEN NAME <u>ANN BERGIN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Helen Arsen (sister) 7829 Old Chester Rd. Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastro-intestinal Hemorrhage</u> DUE TO <u>ESOPHAGEAL VARICES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>LATENT CIRRHOSIS</u> DUE TO <u>HEPATIC ARTERIOVENOUS MALFORMATION</u> (c) <u>HEPATIC ARTERIOVENOUS MALFORMATION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/16</u> , 19 <u>56</u> , to <u>12/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>56</u> , and that death occurred at <u>4:40</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. L. Marks</u> M.D. <u>6306 Wisconsin Ave</u>				DATE SIGNED <u>12/18/56</u>			
PHYSICIAN'S NAME (Type) <u>J. L. MARKS, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial-Transit</u>		<u>12/18/56</u>		<u>Most Holy Redeemer</u>		<u>Schenectady, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED
DEC 14 1936
BUREAU V. A. 3

12693

CERTIFICATE OF DEATH

12661

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington			
c. LENGTH OF STAY IN 1b 2hr.45 min.				d. STREET ADDRESS 4024 Washington Blvd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last MORRIS				4. DATE OF DEATH Month December Day 24 Year 19 56			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-56		9. AGE (In years last birthday) yrs. 2 Min. 45		IF UNDER 1 YEAR Months 2 Days 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Charles L. Morris				14. MOTHER'S MAIDEN NAME Valla Clements			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Mother) Valla L. Morris (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) IMMATUREITY & PREMATUREITY DUE TO PREMATURE LABOR (20 WEEKS GESTATION) 2hr 45 min Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURE DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Dec. , 19 56 , to 24 Dec. , 19 56 , that I last saw the deceased alive on 24 Dec. , 19 56 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-26-56							
ACTUAL SIGNATURE Paul P. McBride M.D.				PHYSICIAN'S NAME (Type) PAUL P. MC BRIDE, I.T MC USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 28 Dec. 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 12-26-56	
24b. REGISTRAR'S SIGNATURE Ray E. Parry							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051286XV6

RECEIVED

NOV 1950

U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12662

Reg. Dist. No.

12679

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If Institution: Residence before admission] a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Road				e. STREET ADDRESS 30 Mannakee Street			
3. NAME OF DECEASED (Type or print) CHARLES E. MOSSBURG				4. DATE OF DEATH Month Dec. Day 7 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 9, 1899	
9. AGE (In years last birthday) 57 yrs.		10. UNDER 1 YEAR 3 Months 28 Days		11. IF UNDER 24 HRS. Hours 28 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor-Self Emp.				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles M. Mossburg				14. MOTHER'S MAIDEN NAME Mary A. Trail			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Yes-Unknown			
17. INFORMANT Mrs Hester E. Mossburg-Item # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/7/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/1956		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) _____ (State) _____ Montgomery Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				24a. REC'D BY REGISTRAR DATE 12/10/56		24b. REGISTRAR'S SIGNATURE Paula Knapton	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

EX-106

BUREAU V. 2

DEC 11 1956

RECEIVED

12694 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Creek Hills-Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 9530 Beall Drive			
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE ESTELLE MYERS				4. DATE OF DEATH Month Day Year 12 26 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/91	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) NEW York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Hallenbeck XXXXXXXXXX				14. MOTHER'S MAIDEN NAME Maggie VanSchoick XXXXXXXXXX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO None		17. INFORMANT John F. Myers Item # 2 Address 5401 E			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 44 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Hypertensive heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 minutes several years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 54 , to 12-26 , 19 56 , that I last saw the deceased alive on 12-26 , 19 56 , and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8519 Hazelwood Drive, Beth., Md. DATE SIGNED 12-29-56							
ACTUAL SIGNATURE K.H. Mish		M.D. 8519 Hazelwood Drive, Beth., Md.					
PHYSICIAN'S NAME (Type) K.H. Mish							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans		22b. DATE THEREOF 12/28/56		22c. NAME OF CEMETERY OR CREMATORY Boonton		22d. LOCATION (City, town, or county) (State) Boonton, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Humphrey ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-29-56		24b. REGISTRAR'S SIGNATURE James W. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

IN 2 17

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12695

CERTIFICATE OF DEATH

12664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 1/2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. STREET ADDRESS 668 - a	
3. NAME OF DECEASED (Type or print) First George Middle Vernon Last Myers, Jr.		4. DATE OF DEATH Month December Day 12 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/56
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George Vernon Myers, Sr.		14. MOTHER'S MAIDEN NAME Edith Marie Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma and Intracranial hemorrhage DUE TO (b) 1 1/2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/11 , 19 56 , to 12/12 , 19 56 , that I last saw the deceased alive on 12/12/56 , 19 56 , and that death occurred at 12:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. S. Whitaker		ADDRESS (Street, city or town, state) Clarksville, Md.	
PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-14-56	22c. NAME OF CEMETERY OR CREMATORY MAYS CHAPEL	22d. LOCATION (City, town, or county) (State) TIMONUM, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. C. HIGGINBOTHAM		24a. REC'D BY REGISTRAR DEC 17 1956	
ADDRESS ELLICOTT CITY MD		24b. REGISTRAR'S SIGNATURE John A. ...	

2073202xv7

BUREAU V. 3

NOV 17 1956

RECEIVED

12665

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Ohio		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 138 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashland		7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1228 Cottage Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose		First Florence		Last Nelson		4. DATE OF DEATH Month December Day 19 Year 1956	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1905	
9. AGE (In years last birthday) 51 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Russell Gwinner				14. MOTHER'S MAIDEN NAME Maude A. Spreng			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforation Cecum and jejunum DUE TO (c) Malignant Melanoma INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 3, 1956 , to December 19, 1956 , that I last saw the deceased alive on December 19, 1956 , and that death occurred at 7:15 P. M. from the causes and on the date stated above. SIGNATURE Arthur J. Garceau M.D. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/20/56 PHYSICIAN'S NAME (Type) Arthur J. Garceau, M. D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/56		22c. NAME OF CEMETERY OR CREMATORY Ashland		22d. LOCATION (City, town, or county) (State) Ashland, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda Md		24a. REC'D BY REGISTRAR DATE 12-22-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

RECEIVED
DEC 11 1964
BUREAU V. A. DUBOIS

12614

CERTIFICATE OF DEATH

12666

Reg. Dist. No.

273

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>700 HUDSON AVE.</i>				d. STREET ADDRESS <i>1120 E Cap. St</i>			
3 NAME OF DECEASED (Type or print) First <i>ELIZABETH</i> Middle <i>L.</i> Last <i>NEWSON</i>				4. DATE OF DEATH Month <i>12</i> - Day <i>7</i> Year <i>1956</i>			
5 SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 9-1878</i>	9. AGE (In years last birthday) <i>78</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i>	IF UNDER 24 HRS. Hours <i></i> Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Real estate</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13 FATHER'S NAME <i>Joe B Fowler</i>				14 MOTHER'S MAIDEN NAME <i>Margaret P. Durnell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <i>Elizabeth Fay</i> Address <i></i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cerebral Thrombosis</i> <i>447.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio-vascular - renal disease</i> DUE TO (c) <i></i>						INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i> <i>4 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i></i> a. m. <i></i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/13/38</i> , 19 <i>38</i> , to <i>12/7/56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12/7/56</i> , 19 <i>56</i> , and that death occurred at <i>3:45</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>811-8-N.E.</i> DATE SIGNED <i>Robt J. Bosworth</i>							
ACTUAL SIGNATURE <i>Robt J. Bosworth</i> M.D. <i>Wash D.C.</i>							
PHYSICIAN'S NAME (Type) <i>Robt J. Bosworth M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>12/19/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Ann's</i>		22d. LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lee's Sons</i> ADDRESS <i>B-3025</i>				24a. REC'D BY REGISTRAR <i></i> DATE <i></i>		24b. REGISTRAR'S SIGNATURE <i></i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

DEC 12 1966

RECEIVED

12697

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 13 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS 4647 S. 34th Street			
3. NAME OF DECEASED (Type or print) First Phyllis Middle Hughes Last O'Neal				4. DATE OF DEATH Month December Day 6th Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1914		9. AGE (In years last birthday) 42 yrs		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-typist		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Oakes				14. MOTHER'S MAIDEN NAME Mable Plunkett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic breast cancer to lungs and bones and probably brain DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 23 , 19 56 , to Dec 6 , 19 56 , that I last saw the deceased alive on Dec 6 , 19 56 , and that death occurred at 11:25 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Chester Z. Haverback M.D.				ADDRESS (Street, city or town, state) National Institute of Health, Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Chester Z. Haverback				DATE SIGNED 12/6/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/56		22c. NAME OF CEMETERY OR CREMATORY St. Hebron		22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 12-8-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 11 1956

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #1</u>			d. STREET ADDRESS <u>R.F.D. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Radie</u> Middle <u>Linella</u> Last <u>Palmer</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-26-88</u>		9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charlie Thompson</u>			14. MOTHER'S MAIDEN NAME <u>Mary Peters</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary A Palmer (daughter) known as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed 6 mo?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Warren Chapel</u>	
22d. LOCATION (City, town, or county) <u>Martinsburg, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert T. ...</u>		ADDRESS <u>Rockville, Md.</u>		24. REC'D BY REGISTRAR <u>141</u>	
24b. REGISTRAR'S SIGNATURE		DATE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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APR 3 1957

LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 12-22-56 at

CERTIFICATE OF DEATH

12669

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>22 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANCIS</u> Middle <u>XXXXXXXX</u> Last <u>PATTON</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-11-06</u>	
9. AGE (In years last birthday) <u>50 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LANDSCAPE</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>John Thornton Patton</u>			
14. MOTHER'S MAIDEN NAME <u>Lola McKimney</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO <u>YES</u>				17. INFORMANT <u>Lillian (wife)</u> Address <u>12807 Colesville Rd SS, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive retroperitoneal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured atherosclerotic abdominal aneurysm</u> DUE TO (c) <u>atherosclerosis generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Dec 18</u> , 19 <u>56</u> , to <u>Dec 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 19</u> , 19 <u>56</u> , and that death occurred at <u>10:15</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D. <u>5237 Georgia Ave Silver Spring Md</u>				DATE SIGNED <u>12/19/56</u>			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Temple</u>				24a. REC'D BY REGISTRAR <u>12-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12630

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>1 year</u>		d. STREET ADDRESS <u>607 Blandford Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>607 Blandford Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>MITCHELL</u> Last <u>PAYNE</u> 3rd.		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1952</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Mitchell Payne 2nd</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Ellis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Father</u>		Address <u>(same as item 2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASPHYXIA</u> <u>491X</u> DUE TO <u>BRONCHOPNEUMONIA, ACUTE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Edema & Fatty metamorphosis of liver</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>20 December 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/22/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Russell Kragtorp</u>	
DATE <u>12/26/56</u>		<u>REC</u>	

RECEIVED

1956

BUREAU V. A.

CERTIFICATE OF DEATH

Reg. Dist. No.

217

12701

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brinklow</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice</u> <u>XXXXXXXX</u> <u>Peirce</u>				4. DATE OF DEATH Month Day Year <u>XXXXXX</u> <u>Dec</u> <u>1</u> <u>1956</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1861</u>	9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Edward Peirce</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Kummer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>Mrs. William Iddings Brinklow, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/30/56</u> to <u>12/1/56</u> , that I last saw the deceased alive on <u>11/30/56</u> , and that death occurred at <u>1:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>12/3/56</u> ACTUAL SIGNATURE <u>C. H. Ligon</u> M.D. PHYSICIAN'S NAME (Type) <u>C. H. LIGON MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brinklow, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laytonville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-6-56</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur B. Lawler</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 14 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12700 CERTIFICATE OF DEATH

Reg. Dist. No.

12671

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 401 Cleveland Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arnold Middle Stephen Last Peterson		4. DATE OF DEATH Month December Day 8 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1950
9. AGE (In years last birthday) yrs 6		IF UNDER 1 YEAR Months 6 Days 18 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Peterson		14. MOTHER'S MAIDEN NAME Phyllis Patton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pontine glioma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month November Day 30 Year 1956 Hour 11 a. m. 30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 30, 1956 to December 8, 1956 , that I last saw the deceased alive on December 8, 1956 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-8-56 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
ACTUAL SIGNATURE Wm M. Headley M.D.			
PHYSICIAN'S NAME (Type) William M. Headley, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/56	
22c. NAME OF CEMETERY OR CREMATORY Rosewood		22d. LOCATION (City, town, or county) (State) Louisburg VA	
23. FUNERAL DIRECTOR'S SIGNATURE Arthuro J. Taylor		24a. REC'D BY REGISTRAR DATE 12-8-56	
ADDRESS 3901 N. Taylor St.		24b. REG. STRAR'S SIGNATURE Kevin Thompson	

RECEIVED

DEC 11 1956

BUREAU V. S.

12631

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Pike, Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverly Sanitarium		d. STREET ADDRESS R.D.D #4	
3. NAME OF DECEASED (Type or print) First Helen Middle C. Last Poerstel		4. DATE OF DEATH Month Dec. Day 3 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/1901
9. AGE (In years last birthday) 55 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Waverly Sanit.	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unobtainable		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Richard Poerstel - 3727 Chesapeake St. N.W. Wash. D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Coronary Thrombosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 12 hours 12 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1954 to Dec 3 1956 , that I last saw the deceased alive on Dec 3 1956 , and that death occurred at 10:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph H. Watson M.D.		ADDRESS (Street, city or town, state) 1822 Baltimore St. N.W.	
PHYSICIAN'S NAME (Type) JOSEPH H. WATSON		DATE SIGNED 12-3-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/5/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		ADDRESS 2901 14th St. N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Laurel H. Hagley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 5 1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12792

CERTIFICATE OF DEATH

12674

Reg. Dist. No. 216

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		d. STREET ADDRESS <u>Glenmar</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jabez H.</u> Last <u>Pool</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1890</u>
9. AGE (In years last birthday) yrs. <u>66</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>10</u> Days <u>7</u> Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. GOVERNMENT</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Pool</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Hendren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT Address <u>Mrs. Katherine Storer</u>		Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>General arteriosclerosis.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-26</u> , 19 <u>56</u> , to <u>12-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-22</u> , 19 <u>56</u> , and that death occurred at <u>125 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paula E. Mahler</u> M.D.		ADDRESS (Street, city or town, state) <u>5311 Roosevelt St. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Paula E. Mahler</u>		DATE SIGNED <u>5311 Roosevelt St. Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>	22b. DATE THEREOF <u>12/25/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>3 Fork Baptist Ch. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Statesville North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Be th. Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-27-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 31 1956
U.S. AIR FORCE

CERTIFICATE OF DEATH

Reg. Dist. No.

12703

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3000 McComas Ave</u>		e. STREET ADDRESS <u>10214 Lorain Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANGELA</u> Last <u>DOPE</u>		4. DATE OF DEATH <u>Dec 21</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2, 1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm P. McNally</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>2210 FET NW</u>	
17. INFORMANT <u>Mrs Gertrude Stewart Washington DC</u>		Address <u>2210 FET NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>BIX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>arterial hypertension</u> DUE TO (c) <u>previous cerebral hemorrhage to hemiplegia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>12 yrs</u> <u>18 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1944</u> to <u>Dec 21, 1956</u> , that I last saw the deceased alive on <u>Dec 20, 1956</u> , and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John V Dolan</u>		ADDRESS (Street, city or town, state) <u>3100 Conn Ave, Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>T. Laseke Sr</u>		DATE SIGNED <u>12/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. Laseke Sr</u>		ADDRESS <u>Hyattsville Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOHEAU V. S.

EC 1850

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12704

CERTIFICATE OF DEATH

12676

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital, Inc		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring (Rural)	
f. STREET ADDRESS Rt 1		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Donald Middle Ralph Last Price		4. DATE OF DEATH Month December Day 10 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/55
9. AGE (In years last birthday) 1 yrs		IF UNDER 1 YEAR Months 11 Days 10 Hours 10 Min.	IF UNDER 24 HRS Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph Price		14. MOTHER'S MAIDEN NAME Edith Garnet James	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia DUE TO Influenza Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) Cerebral Palsy since Birth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) L		INTERVAL BETWEEN ONSET AND DEATH 4 days 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) L	
20c. TIME OF INJURY Month, Day, Year Hour a. m. L p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) L		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/8/56 , 19 56 , to 12/10/56 , 19 56 , that I last saw the deceased alive on 12/9/56 , 19 56 , and that death occurred at 2:00 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring DATE SIGNED 12/10/56 SIGNATURE J. W. Bird, M. D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-56	
22c. NAME OF CEMETERY OR CREMATORY Mount Cal		22d. LOCATION (City, town, or county) (State) Gaithersburg MD	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur C. Gartner, Gaithersburg, Md		24a. REC'D BY REGISTRAR DATE 12-12-56	
24b. REGISTRAR'S SIGNATURE Seamus P. Lawler			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

DEC 19 19

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12677

12705

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>37 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>RT # 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EFFIE</u> Middle <u>Clark</u> Last <u>RABBITT</u>				4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/10</u>		9. AGE (In years lost birthday) <u>46</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Wm. C. Clark</u>				14. MOTHER'S MAIDEN NAME <u>Annie Stiller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>James (husband) RT # 2 Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>114X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abdominal carcinomatosis</u> (c) <u>Adenocarcinoma of the uterus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 month</u> <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. m</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>December 7, 1956</u> , to <u>December 8, 1956</u> , that I last saw the deceased alive on <u>December 9, 1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>				ADDRESS (Street, city or town, state) <u>M.D. 5237 Georgia Ave - Silver Spring, Md. DC 1916</u>			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 251 Carroll St. N.W.</u>				ADDRESS <u>251 Carroll St. N.W.</u>		24a. REC'D BY REGISTRAR <u>EC 12 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Heaven Thompson</u>			

RECEIVED

DEC 17 1950

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12678
Reg. Dist. No. *214*

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> c. LENGTH OF STAY IN 1b <i>9 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3104 Jerning Rd</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Montg</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> d. STREET ADDRESS <i>3104 Jerning Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Paul Morgan Reed</i> First Middle Last		4. DATE OF DEATH Month <i>Dec</i> Day <i>15</i> Year <i>1956</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-9-'86</i>				
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired club</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov.</i>					
11. BIRTHPLACE (State or foreign country) <i>Min.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>					
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>WW I</i> <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <i>none</i>					
17. INFORMANT <i>Wm H. Reed</i>		Address <i>9007 Lewis Ave, Belton, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table style="width: 100%;"> <tr> <td style="width: 50%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td style="width: 50%;"> INTERVAL BETWEEN ONSET AND DEATH <i>Found dead in bed room floor</i> </td> </tr> <tr> <td colspan="2"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) </td> </tr> </table>				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <i>Found dead in bed room floor</i>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <i>Found dead in bed room floor</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <i>0</i> a. m. <i>0</i> p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschant</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>12-15-56</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/18/56</i>					
22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATIONAL CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter L. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>					
24a. REC'D BY REGISTRAR <i>DATE 12/20/56</i>		24b. REGISTRAR'S SIGNATURE <i>Frances Porter</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Forward the original to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
DEC
BUREAU V. E

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 177

12615

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>35 min.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>4615 Madison St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James William Reeves</u>				4. DATE OF DEATH Month Day Year <u>12 - 16 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1928</u>		9. AGE (In years last birthday) <u>28</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Film processor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eastman Kodak</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>John Francis Reeves</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Celestine O'Connor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mother</u> <u>Hospital Records</u> Address <u>Takoma Park, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fracture of skull</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was passenger in auto involved in accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>4:50 a.m.</u> <u>12-16 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Agua Rd</u>		20f. (City or town) (County) (State) <u>Hyattsville Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12-16-56	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/20/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>W.P. & S. Co. Inc. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co - Kilmory, Md.</u>				ADDRESS <u>2615</u>		24a. REC'D BY REGISTRAR <u>2615</u>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the "scale, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 27 1950

BUREAU V. S.

12616

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS 7627 Maple Ave.			
3. NAME OF DECEASED (Type or print) First Awald Middle Henry Last Reich				4. DATE OF DEATH Month December Day 9 Year 1956			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-97	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi-driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi Service		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Henry David Reich				14. MOTHER'S MAIDEN NAME Theresa Josephine Strogies			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rupture of myocardium tamponade DUE TO (b) myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary Occlusion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 min 2 wks 2 wks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11-26 19 56 to 12-9 19 56 , that I last saw the deceased alive on 12-8 19 56 , and that death occurred at 4:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, State) 7701 Carroll Lane DATE SIGNED 12-9-56 ACTUAL SIGNATURE J. M. [Signature] M.D. PHYSICIAN'S NAME (Type) Takoma Park, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 12, 1956		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Skelton				ADDRESS 254 [illegible] NW DC		24a. REC'D BY REGISTRAR DATE 12/14/56	
				24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EO 12156

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 451 West Antietam		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Elizabeth Ritter		First Middle Last		4. DATE OF DEATH Month Day Year 12 9 1956			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/12/1880	
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Mr. Wm Pyles		14. MOTHER'S MAIDEN NAME Anna F. Ferguson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Oldest Son Russell Ritter - phone		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Due to 4 min DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease 20y. DUE TO (c) with Cerebral Anoxia						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cataract Operation 4 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 11/14/56 19 56 to 12/9/56 that I last saw the deceased alive on 12/9/56 and that death occurred at 6 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave DATE SIGNED 12/10/56							
ACTUAL SIGNATURE John J. Curry		M.D.					
PHYSICIAN'S NAME (Type) John J. Curry							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE 12-11-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/SS

BUREAU V. A.

DEC 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12682

12708

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.				d. STREET ADDRESS 1057 Vaughn Street		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Robinson				4. DATE OF DEATH December 10 1956			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1888	
9. AGE (In years lost birthday) 68 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mont. Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Wellington Jackson		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 44 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c) Hypertensive Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 3 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/7 , 19 56 , to 12/10 , 19 56 , that I last saw the deceased alive on Dec 10 , 19 56 , and that death occurred at 8:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6237 Georgia Ave - Silver Spring, Md. DATE SIGNED Dec 12 '56							
ACTUAL SIGNATURE Olson H. Traun		M.D. 6237 Georgia Ave - Silver Spring, Md.					
NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/15/56		22c. NAME OF CEMETERY OR CREMATORY Emory Grove		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. ...		ADDRESS ...		24a. REC'D BY REGISTRAR DEC 19 1956		24b. REGISTRAR'S SIGNATURE ...	

RECEIVED

DEC 1 1950

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12617

CERTIFICATE OF DEATH

12683

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>28 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7315 Baltimore Avenue</u>			d. STREET ADDRESS <u>7315 Baltimore Ave</u>		
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WILLIS</u> Last <u>ROBINSON</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington Territory</u>		11. BIRTHPLACE (State or foreign country) <u>Wales</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Thomas Robinson</u>		
14. MOTHER'S MAIDEN NAME <u>Mary</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>76</u>			17. INFORMANT Address <u>Mrs Sarah E. Robinson, 7315 Baltimore Ave</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Right Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis, Generalized</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour - 10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Gastro Enteritis for 3 days.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>1 Sept</u> , 1956, to <u>16 Dec</u> , 1956, that I last saw the deceased alive on <u>15 Dec</u> , 1956, and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above					
ACTUAL SIGNATURE <u>H. B. Queen</u>		ADDRESS (Street, city or town, state) <u>M.D. 7112 Walton Ave</u>		DATE SIGNED <u>16 Dec 1956</u>	
PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u>		TAKOMA PARK MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Dec 18, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county)	(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walton, 254 Carroll St NW</u>		ADDRESS	24a. REC'D BY REGISTRAR DATE <u>11/18/56</u>	24b. REGISTRAR'S SIGNATURE <u>J. William Bredel</u>	

RECEIVED
DEC 2 1911
BUREAU V. S.

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12709

CERTIFICATE OF DEATH

12684

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland Hill</u>				c. LENGTH OF STAY IN 1b <u>3 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs Md</u>			
				f. STREET ADDRESS <u>2401 Westwind Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Jeanne Bonaparte Robinson</u>				4. DATE OF DEATH <u>12/26/56</u>			
5. SEX <u>W</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-28-1861</u>	
				9. AGE (In years last birthday) <u>95</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done for no. most of working life, even if retired) <u>Retired Butcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VA</u>			
11. BIRTHPLACE (State or foreign country) <u>VA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>David Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Frances B. Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>MISSING</u>			
17. INFORMANT <u>Mrs. Elsie Robinson</u>				Address			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardio Vascular nephros</u> DUE TO <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 3, 1956</u> to <u>Dec 22, 1956</u> , that I last saw the deceased alive on <u>Dec 22, 1956</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. Haule</u> M.D.				ADDRESS (Street, city or town, state) <u>35 NY Ave NW Wash DC</u>			
DATE SIGNED <u>12/26/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>12/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Huntman & Son</u>				ADDRESS <u>5732 K St NW</u>		24a. REC'D BY REGISTRAR DATE <u>12/31/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Francis J. Miller</u>			

RECEIVED

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12710

CERTIFICATE OF DEATH

Reg. Dist. No.

12685
266

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Colorado b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denver	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 955 Downing Street	
3. NAME OF DECEASED (Type or print) First Joseph Middle (no middle name) Last Rothschild		4. DATE OF DEATH Month December Day 10 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 22, 1909
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Building Supply	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Rothschild		14. MOTHER'S MAIDEN NAME Jane Hart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, (not known)) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 322-09-5974	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE 951X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HOMOLOGOUS SERUM HEPATITIS DUE TO (c) Blood TRANSFUSION given for		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malignant Carcinoid c Metastases To Liver		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 5, 1956 , to December 10, 1956 , that I last saw the deceased alive on December 10, 1956 , and that death occurred at 2:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur J. Garceau M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 12/10/56			
PHYSICIAN'S NAME (Type) Arthur J. Garceau, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 12/12/56	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS		24a. REC'D BY REGISTRAR 3501-14A/14	
ADDRESS 3501-14A/14		24b. REGISTRAR'S SIGNATURE Bernard M. Thompson	

BUREAU V. S.

DEC 14 1966

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G208 12-14-56 et

CERTIFICATE OF DEATH

12686

Reg. Dist. No. 216

12711

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherrydale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens, 1st Lane</u>		d. STREET ADDRESS <u>2817-23rd St., North</u>	
3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>D.</u> Last <u>VAH</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1906</u>
9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ashland County, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John A. Deen</u>		14. MOTHER'S MAIDEN NAME <u>Martha Cooley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Funeral Home only</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>old age</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis pneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/29</u> , 19 <u>56</u> , to <u>12/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>12600 PARKLAND DR., ROCKVILLE MD.</u> DATE SIGNED <u>12/14/56</u>			
ACTUAL SIGNATURE <u>Charles M. Weber</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles M. Weber</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>DEC. 5, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHEVY CHASE FUNERAL HOME</u>		ADDRESS <u>5103 Wisconsin Ave., N.W.</u>	
24a. REC'D BY REGISTRAR <u>12-6-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

DEC 11 1956

BUREAU A. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12687

12712

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Indiana b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Wayne			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1238 Oak Street			
3. NAME OF DECEASED (Type or print) First Martin Middle Ferdinand Last Scheele				4. DATE OF DEATH Month December Day 8 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist		10b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Scheele				14. MOTHER'S MAIDEN NAME Mary Meyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 306-05-2612		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) lung carcinoma DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 21 19 56 to December 8, 19 56 , that I last saw the deceased alive on December 8 19 56 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12/9/56 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE S. Weissman M.D.		PHYSICIAN'S NAME (Type) S. WEISSMAN, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/56		22c. NAME OF CEMETERY OR CREMATORY Lutheran		22d. LOCATION (City, town, or county) (State) Ft. Wayne, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-11-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU A 1

DEC 1 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12713 CERTIFICATE OF DEATH

12688

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)			c. LENGTH OF STAY IN 1b 10 mos.		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland			d. STREET ADDRESS 8300 Wisconsin Ave.,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Wilson Middle Reese Last SCOTT			4. DATE OF DEATH Month December Day 13 Year 19 56		
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Oct. 1921	9. AGE (In years lost birthday) yrs 35	F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Clyde W. Scott		
14. MOTHER'S MAIDEN NAME Sarah O. Jones			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT (Wife) Mrs. Clara A. Scott (Same As #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 10 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 6 Nov. 1956 , to 13 Dec. 1956 , that I last saw the deceased alive on 13 Dec. 1956 , and that death occurred at 10:00AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE James E. McClenathan			ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.		
PHYSICIAN'S NAME (Type) James E. Mc Clenathan, LCDR, MC,			DATE SIGNED 12-13-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) Arlington, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey			24a. REC'D BY REGISTRAR 12-13-56		
ADDRESS Bethesda, Md.			24b. REGISTRAR'S SIGNATURE James E. McClenathan		

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12714

CERTIFICATE OF DEATH

12680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Own Home</u>		d. STREET ADDRESS <u>10417 EASTWOOD AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>HALE</u> Middle <u>FRENCH</u> Last <u>SEHORN</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 8, 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV.</u>	9. AGE (In years last birthday) <u>48</u> yrs. If UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> If UNDER 24 HRS: Hours <u> </u> Min <u> </u>
11. BIRTHPLACE (State or foreign country) <u>PRESTON IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>VICTOR SEHORN</u>		14. MOTHER'S MAIDEN NAME <u>BEAULAN FRENCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>DEBORAH H. SEHORN</u>		Address <u>10417 EASTWOOD AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>50</u> to <u>Dec 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>56</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andrews</u> M.D.		ADDRESS (Street, city or town, state) <u>9601 Colesville Rd Silver Spring Md</u>	
DATE SIGNED <u>Dec 15 56</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>		<u>Silver Spring Md</u>	
22a. BURIAL OR CREMATION REMOVAL (Specify)	22b. DATE THEREOF <u>12-18-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME</u>		ADDRESS <u>4812 G.A. AVE WASH DC</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>DEC 21 1956</u>			

RECEIVED

DEC 1956

BUREAU N. Y.

BUREAU V. S.

TO THE

U. S. DEPT. OF JUSTICE

12716 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>NA</u>			
b. CITY OR TOWN (If outside corporate limits, write <u>Bethesda</u> c. LENGTH OF STAY IN 1b RURAL and give nearest town) <u>2 days</u>				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Washington 16 DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>5614 Namatagan Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Isida</u> Middle <u>Servell</u> Last <u>Servell</u>				4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 24/56</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not given</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Cecelia Servell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>✓</u>		17. INFORMANT Address <u>mother same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUB-DURAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RUPTURED TENTORIAL</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County) (State)			
21. I certify that I attended the deceased from <u>Dec 24, 1956</u> to <u>Dec 26, 1956</u> that I last saw the deceased alive on <u>Dec 26, 1956</u> , and that death occurred at <u>2:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John P. Cassidy</u>				ADDRESS (Street, city or town, state) <u>9911 OLD GEORGETOWN RD</u>			
PHYSICIAN'S NAME (Type) <u>JOHN E. CASSIDY M.D.</u>				DATE SIGNED <u>12/26/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Zimmonden</u>				ADDRESS <u>Rock Md</u>		24a. REC'D BY REGISTRAR <u>DAVID</u>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 8 1957

BUREAU OF

12618

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>8707-First Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>SCOTT</u> Middle <u>Sheets</u> Last				4. DATE OF DEATH <u>December 4</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-73</u>	9. AGE (In years last birthday) <u>83</u> yrs	F UNDER 1 YEAR IF UNDER 24 HRS		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John M. Scott</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Fitzhugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u>						<u>8 hours</u>	
4450 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastrointestinal hemorrhage, etiology undet.</u>						<u>48 hours</u>	
DUE TO (c) <u>Generalized arteriosclerosis; H.A.S.H.D.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12-3, 1956</u> , to <u>12-4, 1956</u> , that I last saw the deceased alive on <u>12-4, 1956</u> , and that death occurred at <u>8:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jason Heiger</u>				ADDRESS (Street, city or town, state) <u>931 Bethesda Drive - Silver Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>Jason Heiger, M.D.</u>				DATE SIGNED <u>12-4-56</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumpkey</u>				ADDRESS <u>Silver Spring Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 12/6/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

12619

CERTIFICATE OF DEATH

 126933
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Cornelia</u> Last <u>Sheff</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>6</u> - Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-3-78</u> 78 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Joseph Kent Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Nance</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO <u>Perforated Sigmoid Diverticulum & Abscess</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Diverticulosis</u> DUE TO (c) <u>Chronic Diverticulosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 da</u> <u>10 da.</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>11-27-56</u> , to <u>12-6-56</u> , that I last saw the deceased alive on <u>12-5-56</u> , and that death occurred at <u>7:25 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitlock</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave</u> DATE SIGNED <u>12-6-56</u>			
PHYSICIAN'S NAME (Type) <u>Takoma Park Md</u>							
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacobs Sons Hyattsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10 14 56</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Whitlock</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MUNEAU V. S.

DEC

1911

12620

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>1919 Luzerne Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DALE COLLIER SHERIFF</u>				4. DATE OF DEATH Month Day Year <u>12 23 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-75</u>	
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>John Sherrill</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Ortiz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>15 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 27, 1956</u> to <u>Dec 23, 1956</u> , that I last saw the deceased alive on <u>Dec 23, 1956</u> , and that death occurred at <u>11:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) <u>2701 Carroll Ave</u> DATE SIGNED <u>12-24-56</u>			
PHYSICIAN'S NAME (Type) <u>J. M. Whitlock, M.D.</u>				<u>Takoma Park Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>2903 14th St. N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. B.

DEC

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12621

CERTIFICATE OF DEATH

12696

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Washington DC</u> b. COUNTY <u>Washington DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>				d. STREET ADDRESS <u>5154 8th St. N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Sickle</u> Last <u>Sickle</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>approx 81 yrs</u>	IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min <u>20</u>		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Pending</u>	
13. FATHER'S NAME <u>Shepherd unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Ethel? Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Taken From Chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive heart failure</u> DUE TO (c) <u>Primary Bacillary Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 14</u> 19 <u>56</u> to <u>Dec 20</u> 19 <u>56</u> that I last saw the deceased alive on <u>Dec 20</u> 19 <u>56</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Manchester</u>				ADDRESS (Street, city or town, state) <u>3501 14th St NW</u>			
DATE SIGNED <u>12-20-56</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>BENJAMIN MANCHESTER</u>				ADDRESS <u>Washington DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 23, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OHLEV SHOLOM</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Margulies + Assoc.</u>				ADDRESS <u>3501 14th St NW</u>		24a. REC'D BY REGISTRAR <u>12/26/56</u>	
24b. REGISTRAR'S SIGNATURE <u>William Noel</u>				DATE <u>12/26/56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 209 1-8-57

12717

CERTIFICATE OF DEATH

Reg. Dist. No.

12697

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>421 Gaither Street</u>			
3. NAME OF DECEASED (Type or print) <u>GORDON</u> First <u>Wesley</u> Middle <u>Simmons</u> Last				4. DATE OF DEATH <u>December 15</u> Month <u>15</u> Day <u>1956</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 15, 1936</u>	
				9. AGE (In years last birthday) yrs <u>20</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACK O. Simmons</u>				14. MOTHER'S MAIDEN NAME <u>JANE LAVONNE BENSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>congenital defect</u> DUE TO (c) <u>Cerebral hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis of the aorta</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12/15</u> , 19 <u>56</u> , to <u>12/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>56</u> , and that death occurred at <u>6:30 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas M. Wilson MD</u>				ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave, Bethesda</u>			
PHYSICIAN'S NAME (Type) <u>Thomas M. Wilson, M.D.</u>				DATE SIGNED <u>12/16/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest L. Gaither Gaithersburg Md</u>				24a. REC'D BY REGISTRAR <u>DATE 12-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

2074 263 XV2

RECEIVED

DEC 22 1956

BUREAU V. S.

12718 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 17 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9324 Elmhirst Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AMY Middle AGNES Last SIMONTON				4. DATE OF DEATH Month December Day 9th Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 25, 1879	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 10 Days 14		IF UNDER 24 HRS. Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Andrew Fryburger				14. MOTHER'S MAIDEN NAME Martha Bright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 298-05-5951		17. INFORMANT Son Reginald J. Simonton		Address 9324 Elmhirst Dr. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Heart Disease DUE TO (c) 3 YRS						INTERVAL BETWEEN ONSET AND DEATH INSTANT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Dec 1948 to Dec 1956 , that I last saw the deceased alive on December 9th, 1956 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo I. Donovan M.D.				ADDRESS (Street, city or town, state) 2016 Georgetown Road Bethesda, Md. 12/10/56			
PHYSICIAN'S NAME (Type) LEO I. DONOVAN M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-1956		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md.		24a. REC'D BY REGISTRAR DATE 12-11-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU & S.

100 100

RECEIVED

12719

CERTIFICATE OF DEATH

12699

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nannie Vandyke Skillman</u>		4. DATE OF DEATH Month Day Year <u>12-30-1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-70</u>
9. AGE (in years lost birthday) yrs. <u>86</u>		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. <u>6 5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ernie Myers Skillman</u>		14. MOTHER'S MAIDEN NAME <u>Alice Middleton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Margaret King (Niece)</u>		Address <u>Bethesda, Md. 7200 Bay Jay Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE PERITONITIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>			
554X DUE TO (b) <u>RUPTURED GANGRENOUS GALL BLADDER</u> 3 DAYS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>IMPACTED CALCULI IN COMMON BILE DUCT</u> UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 26, 1956</u> , to <u>Dec. 30, 1956</u> , that I last saw the deceased alive on <u>Dec. 30, 1956</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo M. Curtis</u>		ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>		DATE SIGNED <u>12/31/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-2-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>12-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 82

NOV 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12700

Reg. Dist. No. 218

12720

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>49 W. Diamond Ave</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>P.</u> Last <u>Slaughter</u>		4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24, 1911</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. UNDER 1 YEAR Months <u>0</u> Days <u>9</u>	11. UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Petty Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Hosp, Bethesda</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Russell P. Slaughter</u>		14. MOTHER'S MAIDEN NAME <u>(First name unknown) Cornwall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>244-60-7942</u>	
17. INFORMANT <u>M.C. Police</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic Hemorrhage</u> <u>176 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wound thru left chest (heart)</u> (c) <u>176 X</u> DUE TO (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Self inflicted bullet wound (95 cal. automatic)</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:55 p.m. 12/3/56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Gaithersburg, Montg. Co.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-6-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. onal Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>125-56</u>	
ADDRESS <u>Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Annada L. Cook</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WILLIAM V. S.

1870

1870

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12701

Reg. Dist. No.

12721

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>XXXXXX</u> 3 MO.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12518 Epping Ct</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LORRAINE</u> Middle <u>ANNE</u> Last <u>SMALL</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-18-52</u>	
9. AGE (in years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Neal Small</u>				14. MOTHER'S MAIDEN NAME <u>Jeannette T. Richard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>father - same as item 14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 475X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Upper Respiratory Infection</u> (c) <u>Asphyxia</u> DUE TO stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>12/22/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Chances (Hater)</u>	

9VVVVVVVVVV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

ESMAU A. S.

DEC

RECEIVED

Item 9, Film G209, 1/7/57 for **CERTIFICATE OF DEATH**

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. STATE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY DISTRICT OF COLUMBIA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 108 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 528 10st., N.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Armistead Middle (nmn) Last SMITH				4. DATE OF DEATH Month December Day 27 Year 1956			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-91	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS Hours 1 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Smith				14. MOTHER'S MAIDEN NAME Fannie (Last Name Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous carcinoma of mouth with extensive cervical metastases 14 + X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 year DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1956 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 10 Sept. , 19 56 to 27 Dec. , 19 56 , that I last saw the deceased alive on 26 Dec. , 19 56 , and that death occurred at 1:05 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-28-56							
ACTUAL SIGNATURE James E. McClenathan		M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) James E. Mc Clenathan, LCDR, MC, USNU.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2 Jan 1957	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE L.P. palmer		ADDRESS 412 "A" St., N.E. Washington, D.C.		24a. REC'D BY REGISTRAR DATE 12-28-56	24b. REGISTRAR'S SIGNATURE May E. Parrelly		

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
DEC 91 16 350

12723

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 36 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Smith		4. DATE OF DEATH Month December Day 31 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1952
9. AGE (In years last birthday) 4 yrs		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 56 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Infant Child)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wilbur Smith		14. MOTHER'S MAIDEN NAME Kathryn Barker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Sepsis - pneumonia (c) Acute myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 30 hrs 4 hrs 3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 25, 1956 to December 31, 1956 , that I last saw the deceased alive on December 31, 1956 , and that death occurred at 6:55A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter B. H'Doubler, M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/31/56	
PHYSICIAN'S NAME (Type) PETER B. H'DOUBLER, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 4, 1957	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Jones (press)		24a. REC'D BY REGISTRAR 2847 Wilson Blvd Arlington, Va.	24b. REGISTRAR'S SIGNATURE Beattie M. Hornsby

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 4 1907

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12704

12632

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>3 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>706 Douglas Ave.</u>		d. STREET ADDRESS <u>706 Douglas Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>INA</u> Middle <u>RAY</u> Last <u>SNOWDEN</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1956</u>
9. AGE (In years last birthday) <u>3 wks.</u>		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES F. Snowden</u>		14. MOTHER'S MAIDEN NAME <u>Marion E. Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mother—Marion Snowden</u>		Address <u>706 Douglas Ave. Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>764.0</u> DUE TO <u>Aspiration of Gastric contents</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-15</u> , 19 <u>56</u> , to <u></u> , 19 <u></u> , that I last saw the deceased alive on <u>NEVER</u> , 19 <u></u> , and that death occurred at <u>4:45</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clive E. Jackson, M.D.</u>		ADDRESS (Street, city or town, state) <u>RD 1, Gaithersburg, Md.</u> DATE SIGNED <u>12-15-56</u>	
PHYSICIAN'S NAME (Type) <u>Clive E. Jackson, M.D.</u>		<u>R. D. 1, Gaithersburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>12/17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 18 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Marion Snowden</u>

9VVVVVVVVXVV

BURKEAU A. S.

DEC 20 1956

REC-107

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12724

CERTIFICATE OF DEATH

12705

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 3420 13th St., S.E.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George		Middle (nmn)		Last SOTIRELIS		4. DATE OF DEATH Month December		Day 14		Year 19 56	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 Nov. 1927		9. AGE (in years last birthday) 29 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME George Sotirelis		14. MOTHER'S MAIDEN NAME Pauline (Last Name Unknown)									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 7-9-45 to 12-14-56		16. SOCIAL SECURITY NO. 067 22 5725		17. INFORMANT (Wife) Kathleen Sotirelis (Same As #2)		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema, obstructive of glottis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Infection of Pharynx, organism not yet determined DUE TO (c) 5 days		INTERVAL BETWEEN ONSET AND DEATH 24 hrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 13 Dec. 1956 to 14 Dec. 1956 , that I last saw the deceased alive on 14 Dec. 1956 , and that death occurred at 11:20 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE Harold I. Passes		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.		DATE SIGNED 12-15-56							
PHYSICIAN'S NAME (Type) Harold I. Passes, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 12-15-56		24b. REGISTRAR'S SIGNATURE May E. Parrelly					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 19 1956

RECEIVED

12725

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b 14 yrs.		d. STREET ADDRESS 10,204 COLESVILLE ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,204 COLESVILLE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First GEORGE Middle IZLAR Last SOUTHERN		4. DATE OF DEATH Month DECEMBER Day 15 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1918
9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN	
10b. KIND OF BUSINESS OR INDUSTRY FRANK S. BOWEN, INC.		11. BIRTHPLACE (State or foreign country) WINSTON SALEM, N. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE MINER	
14. MOTHER'S MAIDEN NAME ANNIE E. BETHEIMER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW #2	
16. SOCIAL SECURITY NO. 577-01-3467		17. INFORMANT Mrs. Margaret G. Southern, 10,204 Colesville, Rd. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the tonsil with metastases 145X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from December 15, 1956 , to December 15, 1956 , that I last saw the deceased alive on December 15, 1956 , and that death occurred at 11:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bennet A. Porter, Jr. M.D.		ADDRESS (Street, city or town, state) 9301 Colesville Rd., Silver Spring, Md. DATE SIGNED Dec. 15, '56	
PHYSICIAN'S NAME (Type) BENNET A. PORTER, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/18/56	22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY	22d. LOCATION (City, town or county) (State) PRINCE GEORGE COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey		24a. REC'D BY REGISTRAR DATE 12/20/56	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Francis Foster	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 11 1930

BUREAU V. 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12726

CERTIFICATE OF DEATH

12707

Reg. Dist. No. 216

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7707 Tomlinson AVE.</u>		d. STREET ADDRESS <u>7707-TOMLINSON AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE WALTER SPATES</u>		4. DATE OF DEATH Month Day Year <u>DEC- 29 1956</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3 1908</u>
9 AGE (In years last birthday) <u>48</u> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.C. Transit</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Edward Spates</u>	
14. MOTHER'S MAIDEN NAME <u>Ella Shamlon</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>WIFE - MARY AGATHA SPATES (SAME AS 1.)</u>		17. INFORMANT Address <u>WIFE - MARY AGATHA SPATES (SAME AS 1.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 m.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/19, 1956</u> , to <u>12/29, 1956</u> , that I last saw the deceased alive on <u>12/29, 1956</u> , and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1746 K ST NW</u> DATE SIGNED <u>Wash. 6 D C.</u>			
ACTUAL SIGNATURE <u>S. W. Nealon Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wash. 6 D C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JAN. 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILLSBORO CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>HILLSBORO, VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. DeVol</u> ADDRESS <u>2224 WISAWED</u>		24a. REC'D BY REGISTRAR <u>3-57</u>	24b. REGISTRAR'S SIGNATURE <u>Benjamin M. Thompson</u>

BUREAU V. E.

JAN 7 1957

RECEIVED

12727

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D C b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 11-19-56-12-9-56				d. STREET ADDRESS 2500 Que Street NW			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON Gardens Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) ALFRED		First A Middle STARBIRD Last		4 DATE OF DEATH 12 9 1956		Day 9 Year 1956	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1875	9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Army Officer Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MAINE		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WINFIELD SCOTT STARBIRD				14. MOTHER'S MAIDEN NAME Emmeline Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO WWI		17. INFORMANT Mrs Ethel D Starbird Address 2500 Que St NW Washington DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 440.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Heart Failure (c) Arterio sclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11/27 19 56 to 12/9/56 that I last saw the deceased alive on 12/9/56 19 56 , and that death occurred at 10 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles Weber M.D. DATE SIGNED 12/9/56							
ACTUAL SIGNATURE Charles Weber M.D.							
PHYSICIAN'S NAME (Type) 12/9/56							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawkers Sons ADDRESS 1756 Pa. Ave. NW Wash.				24a. REC'D BY REGISTRAR 12/12/56		24b. REGISTRAR'S SIGNATURE Frances	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Washington

11-18-1955

Washington

Washington

417-11

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DEC 14 1955

RECEIVED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12728

CERTIFICATE OF DEATH

12709

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 7505 BROOKVILLE ROAD			
3. NAME OF DECEASED (Type or print) First ADA Middle LUELLA Last STEVINSON				4. DATE OF DEATH Month DECEMBER Day 15 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 4, 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DAVID WILMONT COCHRAN				14. MOTHER'S MAIDEN NAME MARGARET CATHERINE HILDINGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Wm. F. Smith, 7505 Belvedere Blvd. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm of Cerebral Vessel DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 days 12 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1945 , to Dec. 15 , 19 56 , that I last saw the deceased alive on Dec. 14 , 19 56 , and that death occurred at 6 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William B. Wardrop M.D.				ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring, Md.			
PHYSICIAN'S NAME (Type) WILLIAM B. WARDROP				DATE SIGNED 12/16/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/18/56		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 1-9-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Humphrey			

BUREAU V. S.

DEC 1900

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

21 Item 18& Film 209 1-4-56 BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12729												12710 24	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery						Reg. Dist. No.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 516 Beacon Road						d. STREET ADDRESS 516 Beacon Road							
3. NAME OF DECEASED (Type or print) First Charles Middle Daniel Last Stieglitz						4. DATE OF DEATH Month December Day 6 Year 19 56							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/06		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Specialist				10b. KIND OF BUSINESS OR INDUSTRY ISC		11. BIRTHPLACE (State or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles H. Stieglitz						14. MOTHER'S MAIDEN NAME Mrs. C. D. Stieglitz Same as #2							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 252-01-6890		17. INFORMANT Mrs. C. D. Stieglitz		Address Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined DUE TO (b) Found dead on bedroom floor. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, Autopsy and laboratory findings were neg. DUE TO (c) Autopsy and laboratory findings were neg.										INTERVAL BETWEEN ONSET AND DEATH Found dead on bedroom floor.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found dead on bedroom floor.										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .													
ACTUAL SIGNATURE Frank J. Broschart M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED					
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/6/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/10/56		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY				22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA					
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Funches						ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 12/4/56		24b. REGISTRAR'S SIGNATURE Frances Potter			

RECEIVED

DEC 18 196

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 12/27/56
 12730

CERTIFICATE OF DEATH

12711

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Conneaut		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conneaut		
c. LENGTH OF STAY IN 1b 45 days			d. STREET ADDRESS 236 Liberty Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Robert Middle Earl Last STOOPS			4. DATE OF DEATH Month December Day 27 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Dec. 1878		9. AGE (In years last birthday) 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Indiana	
13. FATHER'S NAME Thomas Jefferson STOOPS		12. CITIZEN OF WHAT COUNTRY? U.S.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1 & II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs Ethel Louise STOOPS (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 1 A D 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Indefinite					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 13 Nov. 1956 to 27 Dec. 1956 , that I last saw the deceased alive on 27 Dec. 1956 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE R. J. Mc Carthy M.D. U.S. Naval Hospital, Bethesda, Md. 12-27-56 PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey			24a. REC'D BY REGISTRAR 12-27-56		24b. REGISTRAR'S SIGNATURE [Signature]

BUREAU V. S.

REC

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12731

CERTIFICATE OF DEATH

12712

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 hr. 7 min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
d. STREET ADDRESS 107 Yale Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Baby Middle Girl Last SWAFFORD				4. DATE OF DEATH Month Dec. Day 3 Year 19 56			
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Dec. 1956	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) yrs 1		IF UNDER 1 YEAR IF UNDER 24 HRS Months 1 Days 7	
11. BIRTHPLACE (State or foreign country) Maryland				12 CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Judson H. Swafford				14. MOTHER'S MAIDEN NAME Annie Myrtle Swafford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Judson H. Swafford (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 7:10.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Erythroblastosis fetalis (c) Erythroblastosis fetalis						INTERVAL BETWEEN ONSET AND DEATH 65 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Dec. , 19 56 , to 3 Dec. , 19 56 , that I last saw the deceased alive on 3 Dec. , 19 56 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Mazur				M.D. U.S. Naval Hospital, Bethesda, Md. 12-4-56			
PHYSICIAN'S NAME (Type) John H. Mazur, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-4-56	
24b. REGISTRAR'S SIGNATURE Barry E. Russell							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051295XV3

BUREAU V. S.

DEC 7 1932

RECEIVED

12732

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8610 2nd AVENUE		e. STREET ADDRESS 8610 2nd AVENUE	
3. NAME OF DECEASED (Type or print) First JESSIE Middle HALLEY Last SWANK		4. DATE OF DEATH Month DEC. Day 5 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 9, 1869
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES HALLEY	
14. MOTHER'S MAIDEN NAME HELEN McDOUGAL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Sidney M. Oliver, 8610 2nd Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5-10 yrs 5-10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-24 , 19 51 , to 12-5 , 19 56 , that I last saw the deceased alive on 12-4 , 19 56 , and that death occurred at 2:38 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE N.T. Lucius		ADDRESS (Street, city or town, state) 9321 Georgia Ave. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) N.T. LUCIUS		DATE SIGNED 12/5/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/7/56	
22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey		24a. REC'D BY REGISTRAR DATE 12/6/56	
24b. REGISTRAR'S SIGNATURE Frances			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1901



12733

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN <u>4 1/2</u> years		d. STREET ADDRESS <u>720 Thayer Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>720 Thayer Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Stuart</u> Last <u>Tingley</u>		4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Foster E. Stuart</u>		14. MOTHER'S MAIDEN NAME <u>Abbie M. Locke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Charles O. Tingley</u>		Address <u>720 Thayer Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 21</u> , 19 <u>56</u> , to <u>Dec. 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 21</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12/23/56</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>1635 Harvard St. N. W., Wash. DC</u> PHYSICIAN'S NAME (Type) <u>Wirth Post Baker</u> <u>1635 Harvard St. N. W., Wash. DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>3. Itland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis C. Collins</u>		ADDRESS <u>321-14th St. N. W., Wash. DC</u>	24a. REC'D BY REGISTRAR <u>12/27/56</u>
24b. REGISTRAR'S SIGNATURE <u>Francis C. Collins</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 31 1
S. A. HARRIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG2021-0-01 56

12731

CERTIFICATE OF DEATH

12715

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS Rt. #2	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Turner Last Turner		4. DATE OF DEATH Month December Day 5 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/88 88
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 56 Min	11. IF UNDER 24 HRS. Months 6 Days 19 Hours 56 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilbert Pierce		14. MOTHER'S MAIDEN NAME Annie Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Hospital Record (Son)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma Cervix 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cholelithiasis DUE TO (c) Shock following Exploration (operation)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1/56 , 19 56 , to 12/4/56 , 19 56 , that I last saw the deceased alive on 12/4/56 , 19 56 , and that death occurred at 2:42 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring DATE SIGNED 12/7/56 ACTUAL SIGNATURE J. W. Bird M.D. Sandy Spring PHYSICIAN'S NAME (Type) J. W. Bird, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 7/56	
22c. NAME OF CEMETERY OR CREMATORY Union Burial Ground		22d. LOCATION (City, town, or county) (State) Montgomery Co MD	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber		24a. REC'D BY REGISTRAR DATE 12/7/56	
24b. REGISTRAR'S SIGNATURE Gertrude B. Lusk			

BUREAU V. S.

DEC 14 1956

RECEIVED

12622

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b 18 days				d. STREET ADDRESS 2817 Parker Court			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Cecelia Last Veitch				4. DATE OF DEATH Month December Day 11 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-24-97	
9. AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY Capital Nurses Reg.		11. BIRTHPLACE (State or foreign country) D. C.	
12. CITIZEN OF WHAT COUNTRY? America							
13. FATHER'S NAME James J. Mc Intyre				14. MOTHER'S MAIDEN NAME Mary Ulrich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive jaundice 105X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obstruction of common duct DUE TO (c) Carcinoma of Gall Bladder INTERVAL BETWEEN ONSET AND DEATH 3 wks Unknown Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 12 , 19 56 , to Dec 11 , 19 56 , that I last saw the deceased alive on Dec 11 , 19 56 , and that death occurred at 9:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 918 Cleworth Drive DATE SIGNED 12-12-56 ACTUAL SIGNATURE Philip C. Jones M.D. PHYSICIAN'S NAME (Type) Silver Spring, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14, 1956		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Orlington, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE C P Jones mds				ADDRESS Orlington, Pa.		24a. REC'D BY REGISTRAR DATE 12/13/56	
24b. REGISTRAR'S SIGNATURE W. H. H. H. H.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12735

CERTIFICATE OF DEATH

12717

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Honeybrook	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) First Charles Middle C. Last Warfel		4. DATE OF DEATH Month December Day 15 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1870
9. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME A. W. Warfel		14. MOTHER'S MAIDEN NAME Christiana Snavelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 205-05-8460	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO 12/15 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Tongue, pharynx DUE TO leptogottis (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 19, 19 56 to December 15, 19 56 , that I last saw the deceased alive on December 15, 19 56 , and that death occurred at 3:58 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gurston Goldin, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) GURSTON GOLDIN		DATE SIGNED 12/18/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/20/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion	22d. LOCATION (City, town, or county) (State) Lancaster, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-18-56	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU W. A.

REC - 17

RECEIVED

12736

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 5338 Wright Ave.,	
3. NAME OF DECEASED (Type or print) First Raymond Middle Gaylen Last WEBSTER		4. DATE OF DEATH Month December Day 20 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 May 1898
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Webster (Deceased)		14. MOTHER'S MAIDEN NAME Mary Pennington (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW-I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Wife) Mrs. Harriet Webster (Same As #2)		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **23 Oct.**, 19**56**, to **20 Dec.**, 19**56**, that I last saw the deceased alive on **20 Dec.**, 19**56**, and that death occurred at **08:00A** M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE **J. T. Horgan** M.D. **U.S. Naval Hospital, Bethesda, Md. 12-20-56**

PHYSICIAN'S NAME (Type) **J. T. HORGAN, LT, MC, USN** **U.S. Naval Hospital, Bethesda, Md.**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-22-56	22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John E. Miller Frieda J. Miller, 2435 E. Oliver, Baltimore, Md.		24a. REC'D BY REGISTRAR DATE 12-20-56	24b. REGISTRAR'S SIGNATURE Theresa E. Parrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC

RECEIVED

12737

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Silver Spring		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 1203 Ballard Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAUDE		First MAY		Middle WHITE		Last WHITE		4. DATE OF DEATH Dec. 28,		Month 19 56		Day 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1888		9. AGE (In years last birthday) 68 yrs		IF UNDER 1 YEAR Months 7 Days 19		IF UNDER 24 HRS Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Hull						14. MOTHER'S MAIDEN NAME Sarah M. Roberts							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Laurence W. White-Item # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liposarcoma, retroperitoneal, & metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>September, 1956</u> , to <u>December 28, 1956</u> , that I last saw the deceased alive on <u>December 27, 1956</u> , and that death occurred at <u>10:10 P.M.</u> , from the causes and on the date stated above.													
ACTUAL SIGNATURE Bennet A. Porter, Jr., M.D.				ADDRESS (Street, city or town, state) 9301 Colesville Rd., Silver Spring, Md.				DATE SIGNED Dec. 28, 1956					
PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/56		22c. NAME OF CEMETERY OR CREMATORY George Washington Mem. Prince George Co., Maryland				22d. LOCATION (City, town, or county) (State) Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				ADDRESS		24a. REC'D BY REGISTRAR 12/31/56		24b. REGISTRAR'S SIGNATURE James Potter					

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be re- by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 1960
U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12720

12623

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7325 BALTIMORE AVE.</u>		d. STREET ADDRESS <u>7325 BALTIMORE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>F.</u> Last <u>WILCOX</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 15, 1870</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOT AVAILABLE</u>		14. MOTHER'S MAIDEN NAME <u>NOT AVAILABLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220 22 516</u>	
17. INFORMANT <u>F. D. C. E. REICHENBAUGH</u>		Address <u>(SAME AS ABOVE)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Complete heart block (several months)</u> DUE TO (c) <u>12 hours</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Complete heart block (several months)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 5, 1956</u> to <u>Dec 5, 1956</u> , that I last saw the deceased alive on <u>Dec 5, 1956</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>John N. Andrew</u> M.D.		ADDRESS (Street, city or town, state) <u>9601 Colverville Rd Silver Spring Md</u>	
DATE SIGNED <u>Dec 6-56</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrew, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT-BURIAL</u>		22b. DATE THEREOF <u>DEC 8, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEW CANTON OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walton</u>		ADDRESS <u>234 CARROLL ST. N.W. DC</u>	
24a. REC'D BY REGISTRAR <u>J. Wilson</u>		24b. REGISTRAR'S SIGNATURE <u>John N. Andrew</u>	
DATE <u>12/8/56</u>			

EUREKA V. S.

DEC 11 1901

RECEIVED

12738

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 1/2 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Arlington			
d. STREET ADDRESS 5322 Yroktown Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Wallace Last WILDE				4. DATE OF DEATH Month December Day 23 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1890		9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inn Keeper		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John A. Wilde				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Address (Son) Ronald B. Wilde, (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular Accident DUE TO (c) Hypertensive or Thrombotic Cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 23 Dec. , 19 56 , to 23 Dec. , 19 56 , that I last saw the deceased alive on 23 December , 19 56 , and that death occurred at 10:35A , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-23-56							
ACTUAL SIGNATURE Russell Miller, Jr.				M.D. U.S. Naval Hospital, Bethesda, Md. 12-23-56			
PHYSICIAN'S NAME (Type) Russell Miller, Jr. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-27-56		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) North Attleboro, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 12-23-56	
				24b. REGISTRAR'S SIGNATURE Russell Miller, Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 1 1941

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12739

CERTIFICATE OF DEATH

12722

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chatham			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5 Overlook Road			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Tschudy Williams				4. DATE OF DEATH Month Day Year December 9, 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH November 29, 1902	
9. AGE (In years last birthday) 54 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry Tschudy				14. MOTHER'S MAIDEN NAME Annie Brunner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 152-28-5735		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic lymphocytic leukemia DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 23, 1956 to December 9, 1956 , that I last saw the deceased alive on December 9, 1956 , and that death occurred at 1:05 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12/9/56 National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-15-56							
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Loss Land Rd. Park		22d. LOCATION (City, town, or county) (State) New Jersey			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward, 4107 Williams Ave							
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE Basem Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 14 1956

RECEIVED

DEC 14 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b Since May '56	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1219 NOYES DRIVE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 1219 NOYES DRIVE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND CARL WILLIAMS		4. DATE OF DEATH Month Day Year DECEMBER 14 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 16, 1907
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President, Capital City Savings & Loan Ass'n.		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Clyde Downs Williams		14. MOTHER'S MAIDEN NAME Grace O. Delabar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Mrs. Madeline S. Williams, 1219 Noyes Drive Silver Spring, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRA K J. BROSCHE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBED		22b. DATE THEREOF 12/17/56	
22c. NAME OF CEMETERY OR CREMATORY FARM LUTHERAN C. F. CH		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey		24a. REC'D BY REGISTRAR 12/17/56	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Frances C. Foster	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BURNING V. S.

DEC 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12741

CERTIFICATE OF DEATH

Reg. Dist. No.

12724

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3521 39th St, N.W.</u>			
3 NAME OF DECEASED (Type or print) <u>Kyle Darby Winkler</u>				4. DATE OF DEATH <u>December 13 1956</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 12/56</u>	9 AGE (In years last birthday) <u>6</u> yrs	10 UNDER 1 YEAR	11 IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Bethesda, Md</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Bartlett Compton Winkler</u>				14. MOTHER'S MAIDEN NAME <u>Marjorie Hawkins</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Mother</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PRE MATURITY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours 48 minutes</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Dec. 12, 1956</u> , to <u>Dec. 13, 1956</u> , that I last saw the deceased alive on <u>Dec. 13, 1956</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Jagers</u>				ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave.</u>			
PHYSICIAN'S NAME (Type) <u>Frank Jagers</u>				DATE SIGNED <u>12/13/56</u>			
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-14-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda Md</u>		24a. REC'D BY REGISTRAR <u>12-14-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>			

2074201XVO

BUREAU V. S.

DEC 17 1906

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12742

CERTIFICATE OF DEATH

12725
214

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 PHILADELPHIA AVENUE		d. STREET ADDRESS 9325 OCALA STREET	
3. NAME OF DECEASED (Type or print) First ROBERTA Middle YATES Last WITHERS		4. DATE OF DEATH Month DEC. Day 23 Year 19 56	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 8, 1878
9 AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FILE CLERK - Federal Bureau of Investigation		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY CLAY YATES		14. MOTHER'S MAIDEN NAME ELIZABETH DESHIELDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Claude B. Claggett, 9325 Ocala St. Silver Spring, Md.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition 4543 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage (2-1-55)		INTERVAL BETWEEN ONSET AND DEATH 3-5 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/16 to 23 Dec , 19 56 , that I last saw the deceased alive on 15 Oct , 19 56 , and that death occurred at 3 P M, from the causes and on the date stated above.			
ACTUAL TIME William D. Aud M.D.		DATE SIGNED 12/24/56	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		Address (Street, city or town, state) Silver Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/26/56	22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 12/27/56	24b. REGISTRAR'S SIGNATURE Francis Potter

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12743

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madison</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center</u>		d. STREET ADDRESS <u>101 East Central Avenue</u>	
3 NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Lincoln</u> Last <u>Withrow</u>		4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 July 1911</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>5</u> Days <u>8</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar J. Withrow</u>		14. MOTHER'S MAIDEN NAME <u>Ann Wittington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>The Medical Record, Clinical Center</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>41 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Rheumatic Carditis</u> (c) <u>Congestive Heart Failure.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial + Aortic Stenosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2 December, 1956</u> , to <u>16 December, 1956</u> , that I last saw the deceased alive on <u>16 December, 1956</u> , and that death occurred at <u>10:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Duncan L. McCollester, M.D.</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Duncan L. McCollester, Md.</u>		DATE SIGNED <u>12/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Tr.</u>	22b. DATE THEREOF <u>12-18-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Madison, Morgan Co Ga</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md</u>	
24a. REC'D BY REGISTRAR <u>12-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bernard M. Kuntz</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

SEP 1 1956

RECEIVED

12741

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>MONTG.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>LEDEAU GARDENS NURSING HOME</u>		d. STREET ADDRESS <u>10504 S DUNMORE RD</u>	
3. NAME OF DECEASED (Type or print) <u>ALICE ROBERTA WOLFREY</u>		4. DATE OF DEATH <u>DEC 28 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 17 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>STANTON VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID SHEARER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Records at Nursing Home, Silver Spring, Md.</u>		Address <u> </u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AORTIC ANEURISM</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT 1956, to DEC 27, 1958, that I last saw the deceased alive on DEC 27, 1958, and that death occurred at 1:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Robert T. Thibadeau, M.D.</u>	ADDRESS (Street, city or town, state) <u>10609 CONCORD ST, KENSINGTON, MD</u>
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>	<u>KENSINGTON, MD</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co</u>		ADDRESS <u>2901-14th St NW</u>	24a. REC'D BY REGISTRAR <u>Francis C. Potter</u>
		DATE <u>12/31/58</u>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. The funeral director may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1967

RECEIVED

12624

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7100 Sycamore Ave</u>		d. STREET ADDRESS <u>4604 Rosedale Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Herbert Alpheus Wrenn</u>		4. DATE OF DEATH <u>Dec 31 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 12 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OR WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles A. Wrenn</u>		14. MOTHER'S MAIDEN NAME <u>Martha A. Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Wm M Lucas - 4604 Rosedale Ave, Bethesda, Md</u>	
17. INFORMANT <u>Wm M Lucas - 4604 Rosedale Ave, Bethesda, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen Arteriosclerosis & Hypertension</u> DUE TO (c) <u>1953</u>		INTERVAL BETWEEN ONSET AND DEATH <u>34 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr Cystitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/13/1955</u> to <u>12/31/1956</u> that I last saw the deceased alive on <u>12/30/1956</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>2030 Carroll Ave</u>	
PHYSICIAN'S NAME (Type) <u>H. T. Morse</u>		DATE SIGNED <u>12/31/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm M Lucas</u>		ADDRESS <u>4604 Rosedale Ave, Bethesda, Md</u>	
24a. REC'D BY REGISTRAR <u>Wm M Lucas</u>		24b. REGISTRAR'S SIGNATURE <u>Wm M Lucas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completedly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

12745

CERTIFICATE OF DEATH

Reg. Dist. No. 2116

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>7110 - 44th STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Summers WRENN</u>		4. DATE OF DEATH Month Day Year <u>12 - 10 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-86</u>
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Charlottesville, Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>White, S. Stuts</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Bailes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs. Wm. Russell (daughter) 7110 - 44th ST. CC, Md.</u>	
17. INFORMANT <u>Mrs. Wm. Russell (daughter)</u>		Address <u>7110 - 44th ST. CC, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute monocytic leukemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 Oct</u> , 19 <u>56</u> , to <u>10 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 Oct</u> , 19 <u>56</u> , and that death occurred at <u>2:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Martyn</u> M.D. <u>5029 Bethesda Ave.</u>		ADDRESS (Street, city or town, state) <u>Beth. Md</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN Jr</u>		DATE SIGNED <u>10 Oct 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>12/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS <u>5029 Bethesda Ave.</u>	
24a. REC'D BY REGISTRAR <u>12-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 19 1906

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12746

CERTIFICATE OF DEATH

Reg. Dist. No. 216

12730

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Cordelia</u> Middle <u>D.</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-19</u>	9. AGE (In years lost birthday) yrs. <u>46</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Calvin G. Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. Annie Bruce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-46-8985B</u>		17. INFORMANT <u>Mrs. E.A. Zimmerman</u>		Address <u>1654 Primrose Rd N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma left breast</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>56</u> , to <u>Dec 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>56</u> , and that death occurred at <u>3:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D.			ADDRESS (Street, city or town, state) <u>3927 INGLEMASS ST NW WASH DC</u>				
PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u>			DATE SIGNED <u>12/16/56</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/18/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>			24a. REC'D BY REGISTRAR <u>12-18-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

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DEC 1 1956

RECEIVED

12747 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2503 KIMBERLY ST.</u>		d. STREET ADDRESS <u>2503 KIMBERLY ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH ELLEN WRIGHT</u>		4. DATE OF DEATH Month Day Year <u>DEC. 28, 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 3, 1863</u>
9. AGE (In years last birthday) <u>93</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>FROSTBURG, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CORNELIUS DAILEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY McCARTNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>THOMAS P. WRIGHT, 2503 KIMBERLY ST. SILVER SPRING, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis 25 years</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1956</u> to <u>Dec 28, 1956</u> , that I last saw the deceased alive on <u>Dec 28, 1956</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.		DATE SIGNED <u>10020 Green Rd. 12/28/56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 31, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PATRICK'S CHURCH CEMETERY CUMBERLAND, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Haller</u>		24a. REC'D BY REGISTRAR <u>1956</u>	
ADDRESS <u>254 CARROLL ST. N.W.</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12732

12748

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN IB 76 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 5815 Sherrier Place, NW,			
3. NAME OF DECEASED (Type or print) First Walter Middle Joseph Last YEBENS				4. DATE OF DEATH Month DEC Day 1 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18 1894	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker				10b. KIND OF BUSINESS OR INDUSTRY District Government		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Cirk YEBENS				14. MOTHER'S MAIDEN NAME Alice RAYNOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Irene D. YEBENS, 5815 Sherrier Place, NW, Wash, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic carcinoma DUE TO (c) CARCINOMA, stomach				INTERVAL BETWEEN ONSET AND DEATH Weeks undetermined "			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 17 , 19 56 , to Dec. 1 , 19 56 , that I last saw the deceased alive on 1 December , 19 56 , and that death occurred at 1:15 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.				DATE SIGNED 12-3-56			
ACTUAL SIGNATURE Wm B Ingram				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Wm. B. Ingram, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home				ADDRESS 3072 "M" St. Wash. D.C.		24a. REC'D BY REGISTRAR DATE 12-2-56	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly							

CERTIFICATE OF DEATH

STATEMENT OF DEATH - BUREAU OF

Jan. 10 1956

Jan. 10 1956

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BUREAU V. 8

REC 4 1956

REC-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12749

CERTIFICATE OF DEATH

12733

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5112 Second Street, N.W.			
3. NAME OF DECEASED (Type or print) First Rose Middle Julia Last Zachrel				4. DATE OF DEATH Month December Day 10 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 January 1933		9. AGE (In years lost birthday) 23 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Pokomo				14. MOTHER'S MAIDEN NAME Mary Blabik			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POST OPERATIVE APNSA & TERMINAL VENTRICULAR FIBRILLATION 410 X DUE TO SURGERY FOR RELIEF OF MITRAL INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATIC HEART DISEASE & MITRAL INSUFFICIENCY 17 YRS. (c) 6 HRS. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. Month 19 Day 19 Year 1956		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 November, 1956 , to 10 December, 1956 , that I last saw the deceased alive on 10 December, 1956 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED Theodore Cooper, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 12/11/56		22b. DATE THEREOF 12/11/56		22c. NAME OF CEMETERY OR CREMATORY Monesson		22d. LOCATION (City, town, or county) (State) Monesson, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-11-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

MADE IN THE STATE OF NEW YORK

BUREAU V. S.

DEC 18 1956

RECEIVED